

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3895

CERTIFICATE OF DEATH

Reg. Dist. No. 03891

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 247 Baltimore Ave.		d. STREET ADDRESS 247 Baltimore Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HELEN First M. Middle AHRENS Last		4. DATE OF DEATH April 19, 19 61 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1897
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Maeby		14. MOTHER'S MAIDEN NAME Margaret Knealy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. INFORMANT Address Henry F. Ahrens 2865 Plainfield Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 28 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 18, 1961 to April 19, 1961 that I last saw the deceased alive on April 19, 1961 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M.B. Davis		M.D. 6800 Monmouth Road	
PHYSICIAN'S NAME (Type) M.B. Davis, M.D.		ADDRESS (Street, city or town, state) Dundalk, Md. DATE SIGNED 4/20/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 22, 1961	
22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Overlea, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE APR 21 '61	
		24b. REGISTRAR'S SIGNATURE Orlino S. Kline	

1880

1880

(M)

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Results of the
Experiments on the
Effect of the
Temperature on the
Rate of the
Reaction of the
Hydrogen Peroxide
with the
Potassium Iodate
Solution

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 3 1961									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05160									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28, Maryland		c. LENGTH OF STAY IN 1b 24 days		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE Maryland		b. COUNTY 3 v 01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 116 S. Culver Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Amer		4. DATE OF DEATH Month April Day 28 Year 19 61							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/87	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman, Ret'd.		10b. KIND OF BUSINESS OR INDUSTRY Belle City		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John H. Amer				14. MOTHER'S MAIDEN NAME Mary Caldwell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 218-26-3453		17. INFORMANT Address RECORDS: Spring Grove State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 14, 19 61 to April 28, 19 61 , that (I) (we) last saw the deceased alive on April 28, 19 61 and that death occurred at 9 a. M. from the causes and on the date stated above.									
22a. SIGNATURE Loretta Hsu		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 28, 1961					
22c. PHYSICIAN'S NAME (Type) Loretta Hsu M.D.		22d. ADDRESS Spring Grove State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2/61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Belle, Md			
24. FUNERAL DIRECTOR'S SIGNATURE Witzke, 4101 Edmondson Ave				ADDRESS 4101 Edmondson Ave		25a. REC'D BY REGISTRAR MAY 3 '61		25b. REGISTRAR'S SIGNATURE Adeline S. Huns	

03100

CENTRAL OFFICE OF DEATHS

03800

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(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3897

CERTIFICATE OF DEATH

Reg. Dist. No. 03892

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1918 Stanhope Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERBERT E. AMEY SR.		4. DATE OF DEATH April 17 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1896
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George E. Amey		14. MOTHER'S MAIDEN NAME Sophia Kaiser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Lucille Amey		Address 1918 Stanhope Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the right lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3-2-61
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-2-1961 to 4-17-1961 that I last saw the deceased alive on 4-16-1961 and that death occurred at 1:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Mornington Rd Dundalk, Md. DATE SIGNED 4-19-61			
ACTUAL SIGNATURE Eugene F Neve M.D.		PHYSICIAN'S NAME (Type) Eugene F Neve	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-21-1961	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., ADDRESS 1901 Eastern Avenue		24a. REC'D BY REGISTRAR APR 19 61	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3893

03893

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HENRY - W - ARMACOST</u> First Middle Last				4. DATE OF DEATH <u>April 13</u> 19 <u>61</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 8 - 1874</u> 86 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H Annacost</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>2-17-07-5186</u>		17. INFORMANT <u>Robert Annacost - Upperco MD</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> p. m.				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> 19 <u>61</u> , to <u>April 13</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Apr 13</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush - MD</u>				22d. ADDRESS <u>Hampstead Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-15-1961</u>		<u>St Pauls</u>		<u>Balto Co MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Gipton</u> ADDRESS <u>Hampstead MD</u>				25a. REC'D BY REGISTRAR DATE <u>APR 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3899 CERTIFICATE OF DEATH 03894

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Conv. Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 305 Alabama Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEAH DEMOLL BAILY		4. DATE OF DEATH April 21, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1907 9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Otto J. DeMoll		14. MOTHER'S MAIDEN NAME Mamie Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frederick R. Baily		Address 305 Alabama Rd. Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 962 X DUE TO Conditions, if any, which gave rise to immediate cause (b) INANITION (c) OLD BRAIN INJURY (LACERATION) cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURED HIP (RIGHT)		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 MOS. 8 YEARS	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PATIENT FELL AT HOME	
20c. TIME OF INJURY Month, Day, Year Hour a.m. OCT. 19 59 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) TOWSON (County) BALTIMORE (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 10/2 , 19 55 , to 4/21 , 19 61 , that (I) (we) last saw the deceased alive on 4/20 , 19 61 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Donald L. Somerville M.D.		22b. DATE SIGNED 4/22/61	
22c. PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE		22d. ADDRESS 25 W. PA. AVE, TOWSON 4, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 24/61	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens		23d. LOCATION (City, town or county) Timonium, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		25a. REC'D BY REGISTRAR APR 24 '61 DATE	
ADDRESS York Rd. Towson, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	



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Salisbury

Salisbury

London

London

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London General, London

April 21, 1961

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April 21, 1961

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3000

03895

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Lytl1lmth7dys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 21 North Carey Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harry		First		Middle		Last Bankard		4. DATE OF DEATH Month April	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Fe. 14, 1888		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Eugene Bankard		14. MOTHER'S MAIDEN NAME Mamie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-07-2916-A		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized and severe		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)		20j. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 22, 1961 to April 1, 1961, that (I) (we) last saw the deceased alive on April 1, 1961 and that death occurred at 1:30 P.M. from the causes and on the date stated above		22a. SIGNATURE Stella Wachler		22b. DATE SIGNED 4-4-61		22c. PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/61		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.		23d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE The MacNabb Funeral Home, Catonsville, Md.		25a. REC'D BY REGISTRAR DATE APR 5 '61		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

014

SV 1-4

1



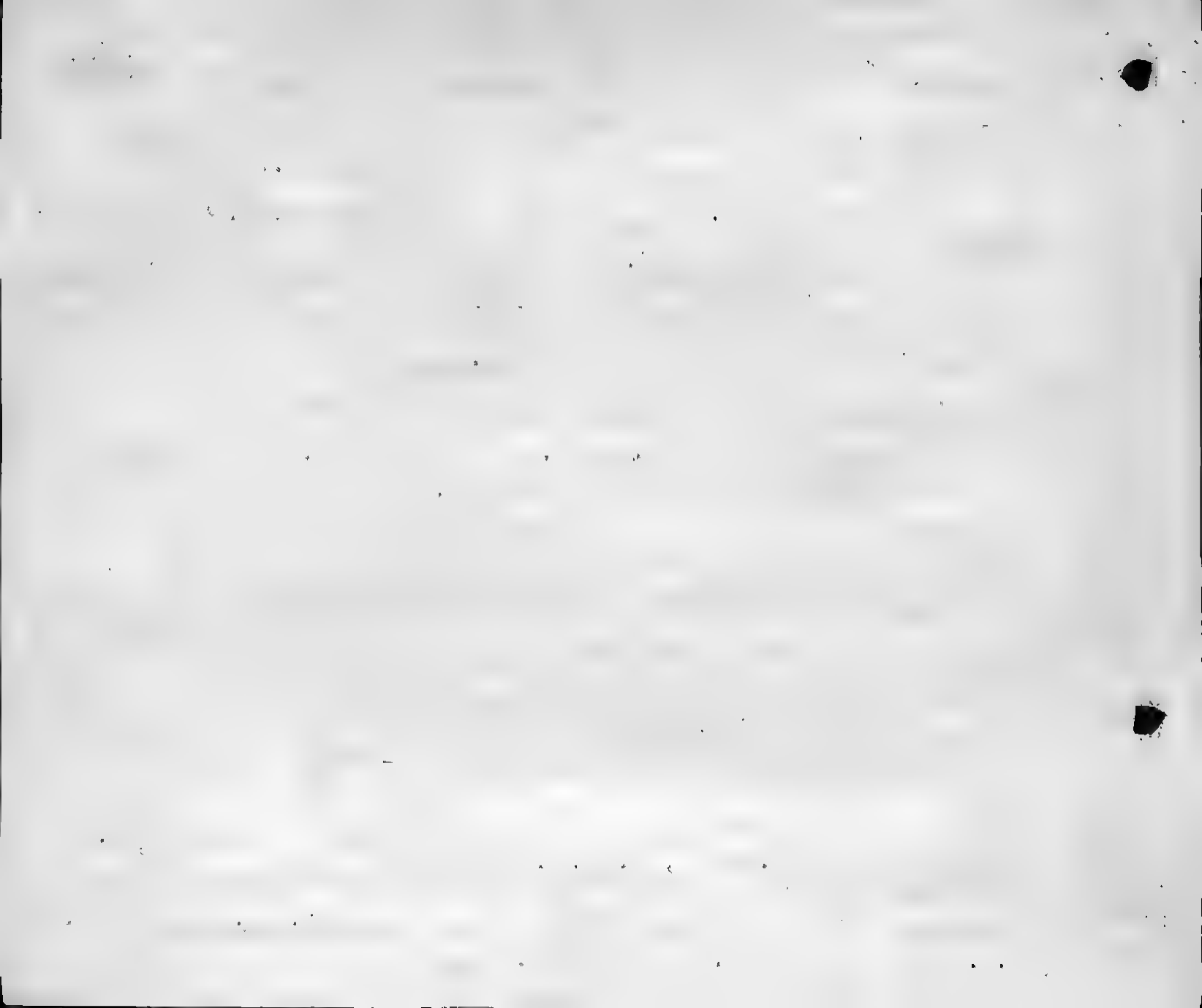
3901

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03896

1. PLACE OF DEATH Items 20 & 21, Film G-287		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)	
a. COUNTY BALTIMORE	b. STATE MARYLAND	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Co., (Towson)	d. STREET ADDRESS 418 Overbrook Rd. -12
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JUNE P. BOGUE	4. DATE OF DEATH Month April Day 26 Year 19 61		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-1918
9. AGE (In years last birthday) 42 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME H. Norbert Paul	14. MOTHER'S MAIDEN NAME Charlotte Trumbo		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO ?	17. INFORMANT H. Norbert Paul Jr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Overdose of barbiturates. IMMEDIATE CAUSE (a) 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Took overdose of sleeping pills.		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4 / 7 / 61 Found: p.m. 5:15 PM 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Baltimore, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr., M. D.		DATE SIGNED April 27, 1961	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-61	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or country) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR F. J. Jenkins & Son Co. 4905 York Rd.		24a. REC'D BY REGISTRAR APR 28 '61	
		24b. REGISTRAR'S SIGNATURE Wm. S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

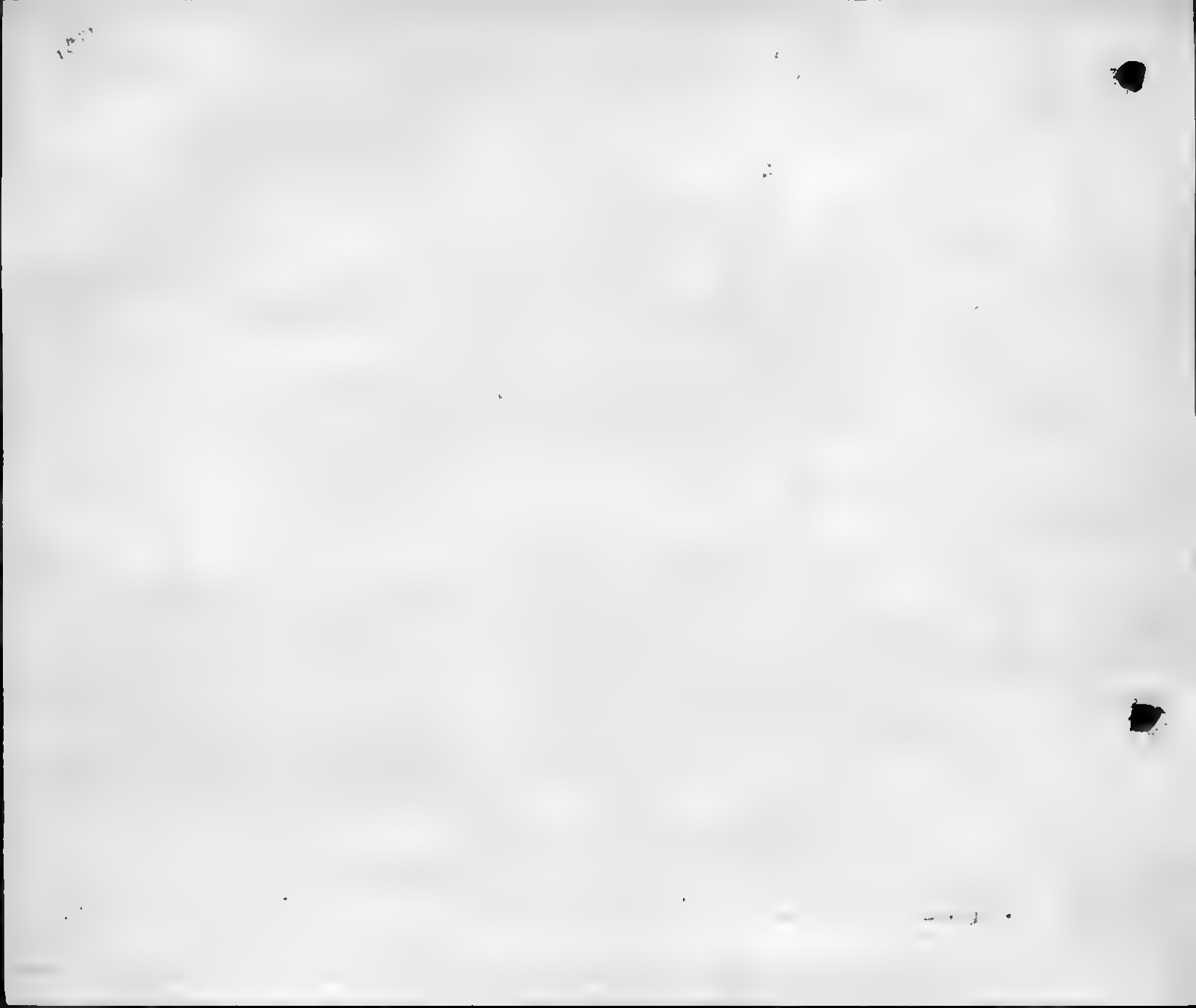
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2302

Items 2 & 13 Film G205 5/1/61 iwk

03897

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ARMACOST N.H.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 529 ANNESLIE RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle R. Last BORLAND		4. DATE OF DEATH Month 4 Day 22 Year 1961	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 7, 1879	
9. AGE (In years last birthday) 82 Yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES W. BORLAND Coleman		14. MOTHER'S MAIDEN NAME MARTHA JANE GOBRECHT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT MRS. MAUD C. ANDERSON Address ABOVE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 311 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) General atherosclerosis DUE TO - (c) -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1954 to Sept. 22, 1961 , that (I) (we) last saw the deceased alive on Apr. 22, 1961 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Frederick J. Vellmer M.D.		22b. DATE SIGNED 4-24-61	
22c. PHYSICIAN'S NAME (Type) FREDERICK J. V-LLMER		22d. ADDRESS 6100 YORK RD BALTIMORE - 12 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-26-61	
23c. NAME OF CEMETERY OR CREMATORY NEW OXFORD		23d. LOCATION (City, town or county) (State) NEW OXFORD PA	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS Co. ADDRESS 4905 YORK RD.		25a. REC'D BY REGISTRAR APR 24 '61	
		25b. REGISTRAR'S SIGNATURE Arthur J. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2003

CERTIFICATE OF DEATH

Reg. Dist. No.

03898

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 1yr4mth3dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 15 Shady Nook Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith Boswell		4. DATE OF DEATH Month April Day 18 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1888
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joh--unknown-- George W. Jackson		14. MOTHER'S MAIDEN NAME unknown----Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized, severe. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 11, 1961 to April 18, 1961 , that I last saw the deceased alive on April 18, 1961 , and that death occurred at 9:10 a M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslor M.D. SPRING GROVE STATE HOSPITAL			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachslor M.D.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-1961	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Howard County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Max R. H. T. H.		ADDRESS 301 Frederick Road-28-	
24a. REC'D BY REGISTRAR APR 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 3, 8 taken from birth certificate on file, 4/11/72 kam 03899

1. PLACE OF DEATH
e. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Timonium
c. LENGTH OF STAY N 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2109 Pine Valley Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Baltimore
b. COUNTY Timonium
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2109 Pine Valley Drive
d. STREET ADDRESS 2109 Pine Valley Drive

3. NAME OF DECEASED (Type or print) James HOWARD Boyd
4. DATE OF DEATH April 15 1961
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH 1-21-1914
9. AGE (in years (if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) Months Days Hours M n. 47 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supr. Construction
10b. KIND OF BUSINESS OR INDUSTRY Maryland
11. BIRTHPLACE County & State or foreign country
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harry A. Boyd
14. MOTHER'S MAIDEN NAME Margaret Hayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO. 217-03-5623
17. INFORMANT Mrs. Margaret E. Boyd Address Care

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO (b) Coronary Insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Sudden
Interval between onset and death 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19
20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

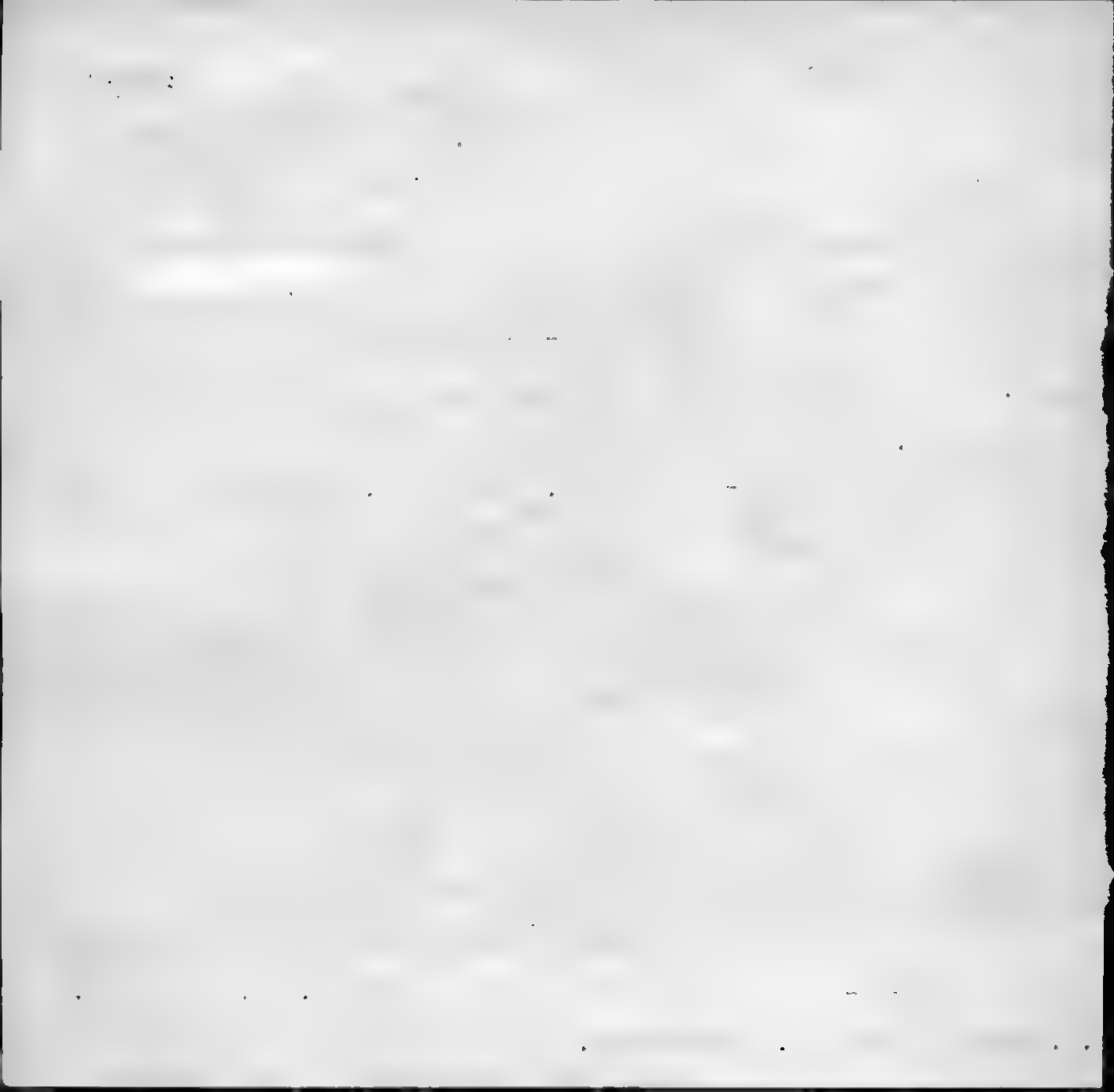
21. I certify that (I) (this hospital) attended the deceased from Oct 13 1961 to April 13 1961, that (I) (we) last saw the deceased alive on April 13 1961, and that death occurred at 7:45 M, from the causes and on the date stated above.

22a. SIGNATURE Charles F. O'Donnell M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED April 13 1961
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell 22d. ADDRESS 7501 York Rd - Towson Md

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 4-18-61
23c. NAME OF CEMETERY OR CREMATORY Morland Memorial
23d. LOCATION (City, town or county) (State) Balto. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE W. Jenkins & Sons Co. ADDRESS 4905 York Rd.
25a. REC'D BY REGISTRAR APR 18 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Hines

MEDICAL CERTIFICATION

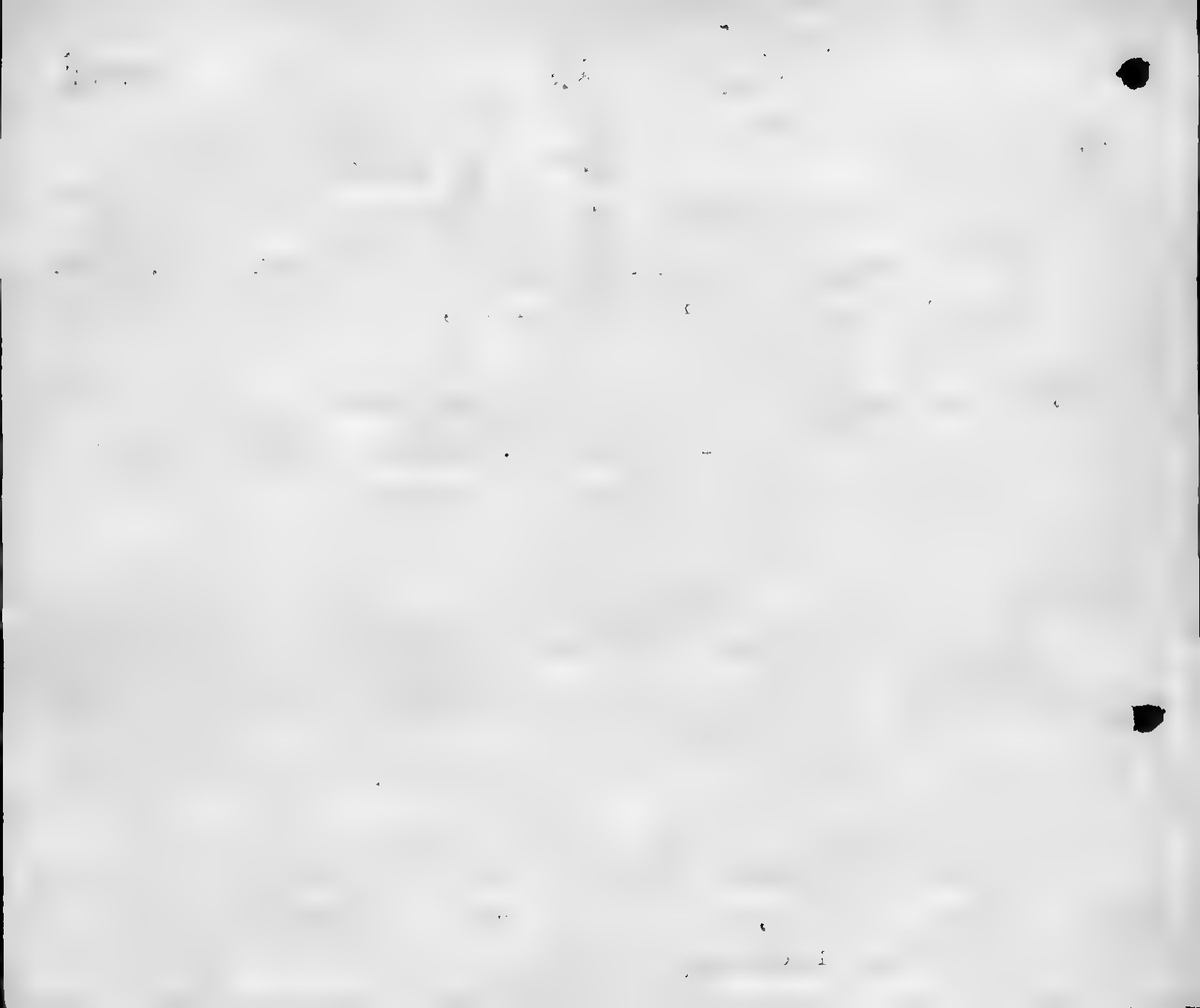


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
3905											
03900											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before death, if not) e. STATE Maryland							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b MIDDLE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Convalescent Home 301 West Chesapeake Avenue				d. STREET ADDRESS 825 West 35th Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mattie Breidinger				4. DATE OF DEATH April 12, 1961				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH March 25, 1876			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years last birthday) 85 yrs.			
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME John Foxwell			
14. MOTHER'S MAIDEN NAME Molly Lusby				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO -----			
17. INFORMANT Mrs. Marie Jones				Address 825 West 35th Street				18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease				DUE TO 422.1				INTERVAL BETWEEN ONSET AND DEATH 5 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Parkinson's Disease				1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (the hospital) attended the deceased from April 1, 1961, to April 12, 1961, that (I) (we) last saw the deceased alive on April 10, 1961, and that death occurred at 8 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Philip D. Lynn				22b. DATE SIGNED April 12, 1961				22c. PHYSICIAN'S NAME (Type) Philip D. Lynn, M.D.			
22d. ADDRESS 116 Chase St				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 15, 1961				23c. NAME OF CEMETERY OR CREMATORY New Cathedral			
23d. LOCATION (City, town or county) Baltimore, Maryland				23e. REC'D BY REGISTRAR DATE APR 17 '61				23f. REGISTRAR'S SIGNATURE Arthur S. Klaus			
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Norace A. Burgee				ADDRESS 3631 Falls Road Baltimore							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2006

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 125 North Colvin		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle S Last BROWN				4. DATE OF DEATH Month April Day 14 Year 19 61			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1892		9. AGE (in years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Plasterer (retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph S. Brown				14. MOTHER'S MAIDEN NAME Savannah Searles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WA-1 217-05-8312		17. INFORMANT Address Clin Rec VAH Balto Md - Ft Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR RIGHT PARIETAL REGION DUE TO Conditions, if any, which gave rise to immediate cause (b) PULMONARY EDEMA (a), stating the underlying cause last, DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) NO					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NO		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) MELVIN B. DAVIS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		4-15-61	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-61		22c. NAME OF CEMETERY OR-CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 1808-10 N. Monroe St Arlington S Phillips Baltimore 17, Md.				24a. REC'D BY REGISTRAR DATE APR 18 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

MEDICAL CERTIFICATION



may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

3907

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03902

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. LENGTH OF STAY IN 1b 37 yrs 6 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 2756 Fenwick Avenue			
3. NAME OF DECEASED (Type or print) First Meta Middle Busig Last Busig				4. DATE OF DEATH Month April Day 25 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1883	
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Frederick Nolcke				14. MOTHER'S MAIDEN NAME Mary Gunneman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. 218 31-1383			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1961 to April 25, 1961 , that (I) (we) last saw the deceased alive on April 25, 1961 , and that death occurred at A. M. from the causes and on the date stated above							
22a. SIGNATURE Stella Wachsler M.D.				22b. DATE SIGNED 1:05			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler M.D.				22d. ADDRESS Spring Grove State Hospital Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/28/61		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK BALTIMORE MARYLAND.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.				25a. REC'D BY REGISTRAR MAY 1 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

MEDICAL CERTIFICATION

INTERVAL BETWEEN DEATH AND DEATH



CERTIFICATE OF DEATH

3908

05184

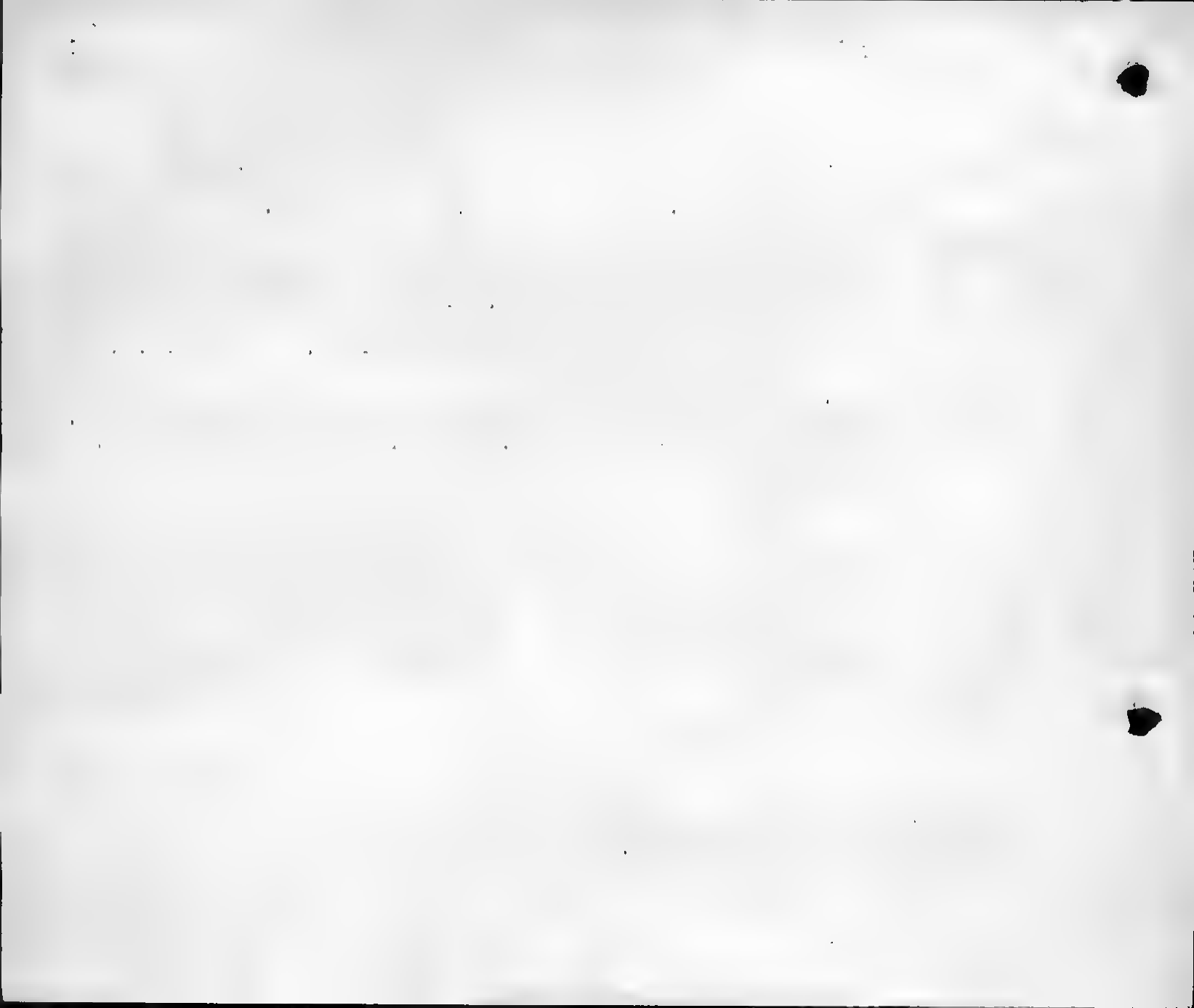
Item 9 Film 0207 5/22/01 mr

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md.		b. COUNTY		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Pikesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pikesville 8, Md.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		707 Careysbrook Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		707 Careysbrook Rd.		d. STREET ADDRESS		707 Careysbrook Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		Roger		Ernest		Butts		4. DATE OF DEATH		April 30,		19 61	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		Dec. 12, 1902	
9. AGE (In years, last birthday)		59		10. IF UNDER 1 YEAR		Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Salesman		10b. KIND OF BUSINESS OR INDUSTRY		George L. Reed		11. BIRTHPLACE (State or foreign country)		Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
11. BIRTHPLACE (State or foreign country)		Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		U.S.A.							
13. FATHER'S NAME		Arthur U. Butts		14. MOTHER'S MAIDEN NAME									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		No		16. SOCIAL SECURITY NO		212-10-7529		17. INFORMANT		Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Coronary Occlusion - Hypertensive C. Disease -		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1961</u> to <u>April 30, 1961</u> , that (I) (we) saw the deceased alive on <u>April 30, 1961</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above													
22a. SIGNATURE <u>Thomas E. Wheeler</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)		THOMAS E. WHEELER		22d. ADDRESS		Randallstown - Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		May 3, 1961		23c. NAME OF CEMETERY OR CREMATORY		Woodlawn Cemetery		Woodlawn, Maryland	
23d. LOCATION (City, town, or county)				23e. REC'D BY REGISTRAR		DATE MAY 17 '61		23f. REGISTRAR'S SIGNATURE		Arthur L. Thomas			
24. FUNERAL DIRECTOR'S SIGNATURE		Frank H. Newell		ADDRESS		Pikesville, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

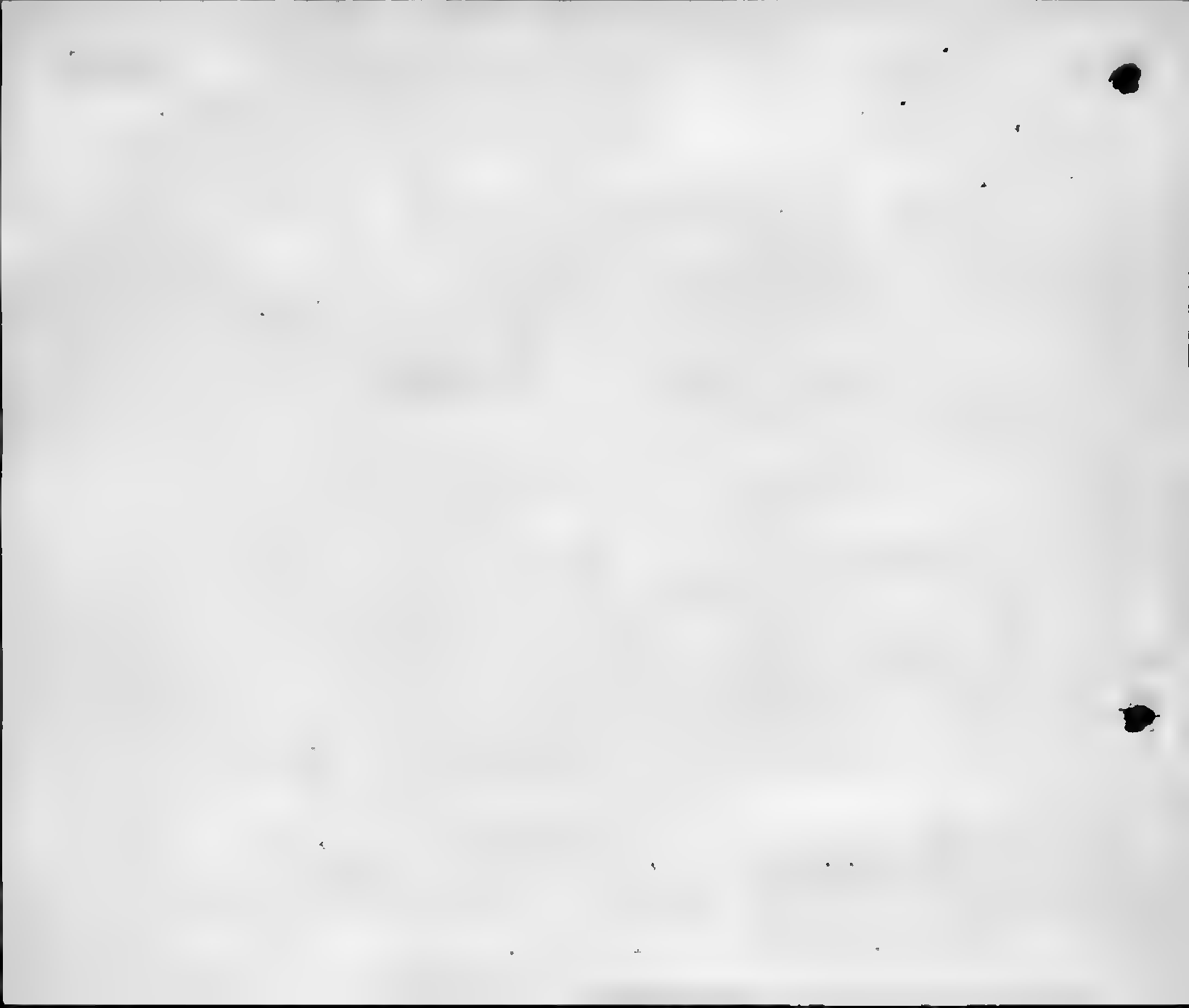
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15M 9/59



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.
(M)

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
2909 03903											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town <u>Arbutus</u> c. LENGTH OF STAY IN 1b <u>Arbutus</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>4807 Westland Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Frances Campbell</u>			4. DATE OF DEATH Month Day Year <u>April 14, 1961</u>								
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>April 14, 1919</u>		
9. AGE (In years last birthday) <u>81 yrs.</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>House duties</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John Winter</u>			14. MOTHER'S MAIDEN NAME <u>Mary Sharpley</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>	
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Mary Sharpley</u>			Address <u>4807 Westland Blvd</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis. Cardio vascular heart disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Geo. J. Antieffer</u> M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. J. Antieffer</u>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>4807 Westland Blvd</u>										DATE SIGNED <u>April 14, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>3/18/61</u>			22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore Maryland</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		
23. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>					ADDRESS <u>4107 Wilkens Ave.</u>					24a. REC'D BY REGISTRAR <u>APR 19 61</u>	
										24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

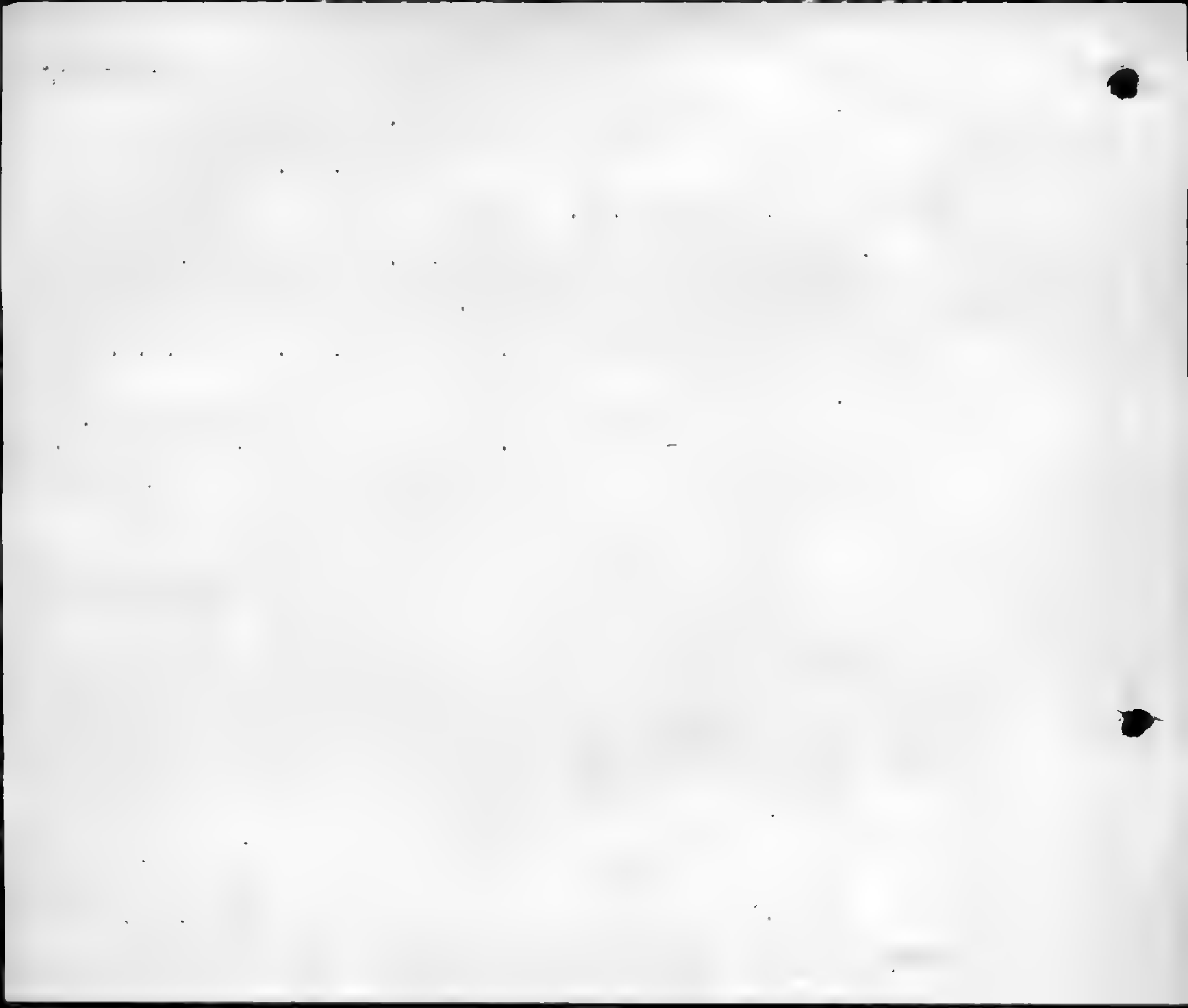
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2910

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03904

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Stevenson		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stevenson Road, Stevenson, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle William Last Caple, Sr.		4. DATE OF DEATH Month April Day 27 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1894
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY American Oil Co. Carroll CO., Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles C. Caple		14. MOTHER'S MAIDEN NAME Catherine Shipley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 216-10-0765	
17. INFORMANT Stevenson, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) generalized arteriosclerosis DUE TO (c) several yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 28 Apr. 1961 , that (I) (we) last saw the deceased alive on 25 Apr. 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above			
22a. SIGNATURE Paul H Royse		22b. DATE SIGNED 28 Apr 61	
22c. PHYSICIAN'S NAME (Type) PAUL H ROYSE		22d. ADDRESS 1403 Foley Lane Pikesville 8, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1961	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville 8, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Frank A. Newell, Pikesville 8,		25a. REC'D BY REGISTRAR MAY 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03905**

3911

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Stevenson, Md.		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stevenson, Md.				d. STREET ADDRESS Stevenson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Vivin Last Carey, Sr.				4. DATE OF DEATH Month April Day 15 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1896		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Baltic Co. Md.		11. BIRTHPLACE (State or foreign country) Stevenson, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Edward Carey				14. MOTHER'S MAIDEN NAME Martha Simons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-07-4990		17. INFORMANT Mrs. Ida Mae Carey, Stevenson Rd.,		Address Stevenson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							5 min.
DUE TO 4201							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Angina							4 yrs.
DUE TO							
(c) Arteriosclerotic C-V Disease							7 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1961		22c. NAME OF CEMETERY OR CREMATORY Jessups Cemetery		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				24a. REC'D BY REGISTRAR PR 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3912

CERTIFICATE OF DEATH

03906

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN 1b

32 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF DECEASED
(Type or print)

EDGAR

W.

CARR

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

July 20, 1892

4. DATE OF DEATH

April 22, 1961

9. AGE (in years last birthday)

68 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Insurance Underwriter

10b. KIND OF BUSINESS OR INDUSTRY

Insurance

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander O. Carr

14. MOTHER'S MAIDEN NAME

Katherine Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

WW-1

16 SOCIAL SECURITY NO. 17 INFORMANT **VAH, 3900 Loch Raven Blvd. Balto 18, Md. FORT HOWARD DIVISION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

CEREBROVASCULAR ACCIDENT

(c)

INTERVAL BETWEEN ONSET AND DEATH
1 WEEK

RECENT

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

2Da ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town)

(County)

(State)

21. I certify that ☒ (this hospital) attended the deceased from **March 21, 1961** to **April 22, 1961**, that ☒ (we) last saw the deceased alive on **April 22, 1961**, and that death occurred at **8:15 A.M.** from the causes and on the date stated above.

22a. SIGNATURE

M. Lawrence Rubin

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED
4/22/61

22c. PHYSICIAN'S NAME (Type)

M. LAWRENCE RUBIN, M.D.

22d. ADDRESS

VAH Baltimore 18, Md. FORT HOWARD DIVISION

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE THEREOF

4-30-61

23c. NAME OF CEMETERY OR CREMATORY

Arlington National Cemetery Fort Meyer, Virginia

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

William Cook-Blight, Inc. Baltimore, Md.

25a. REC'D BY REGISTRAR

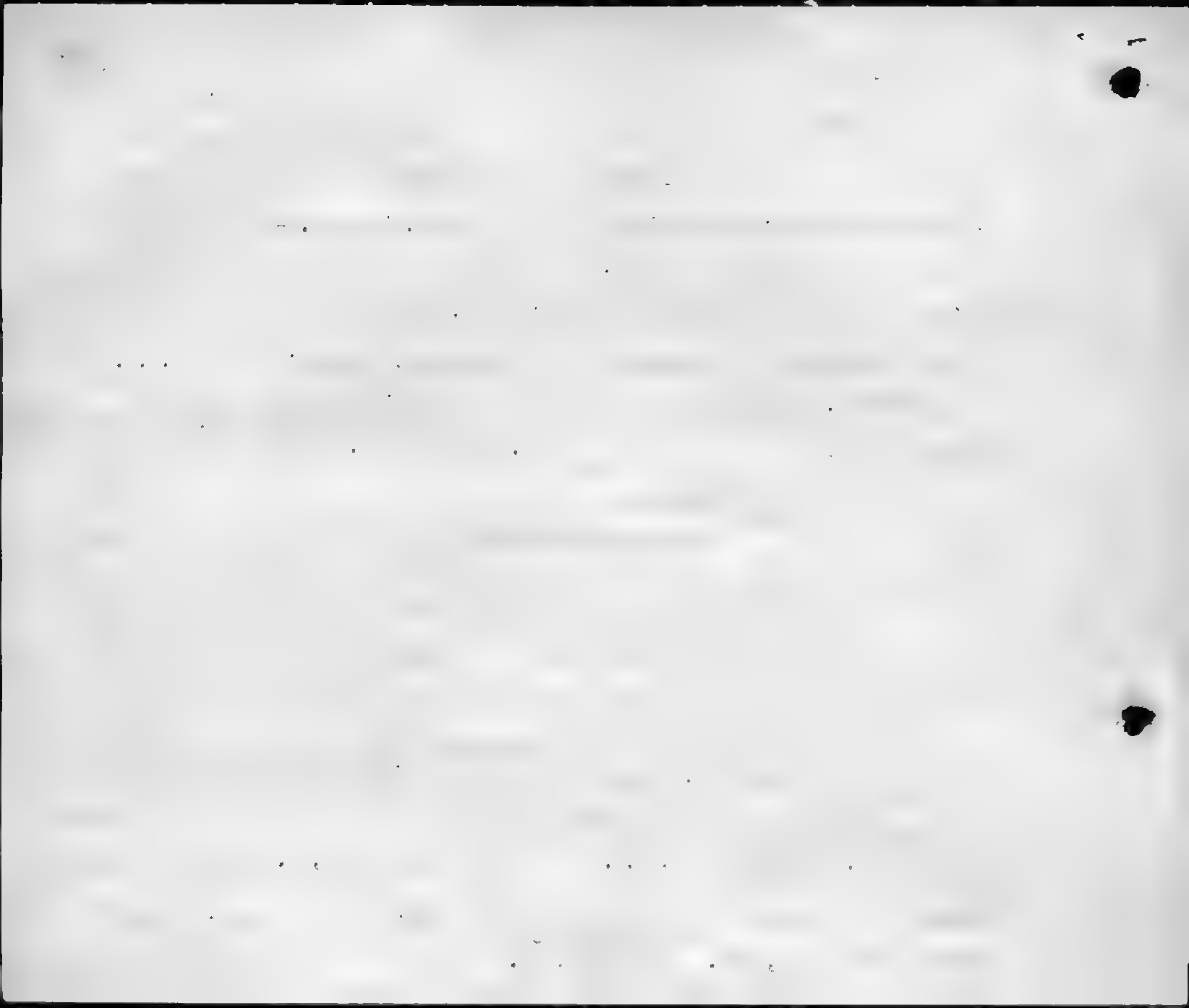
MAY 1 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

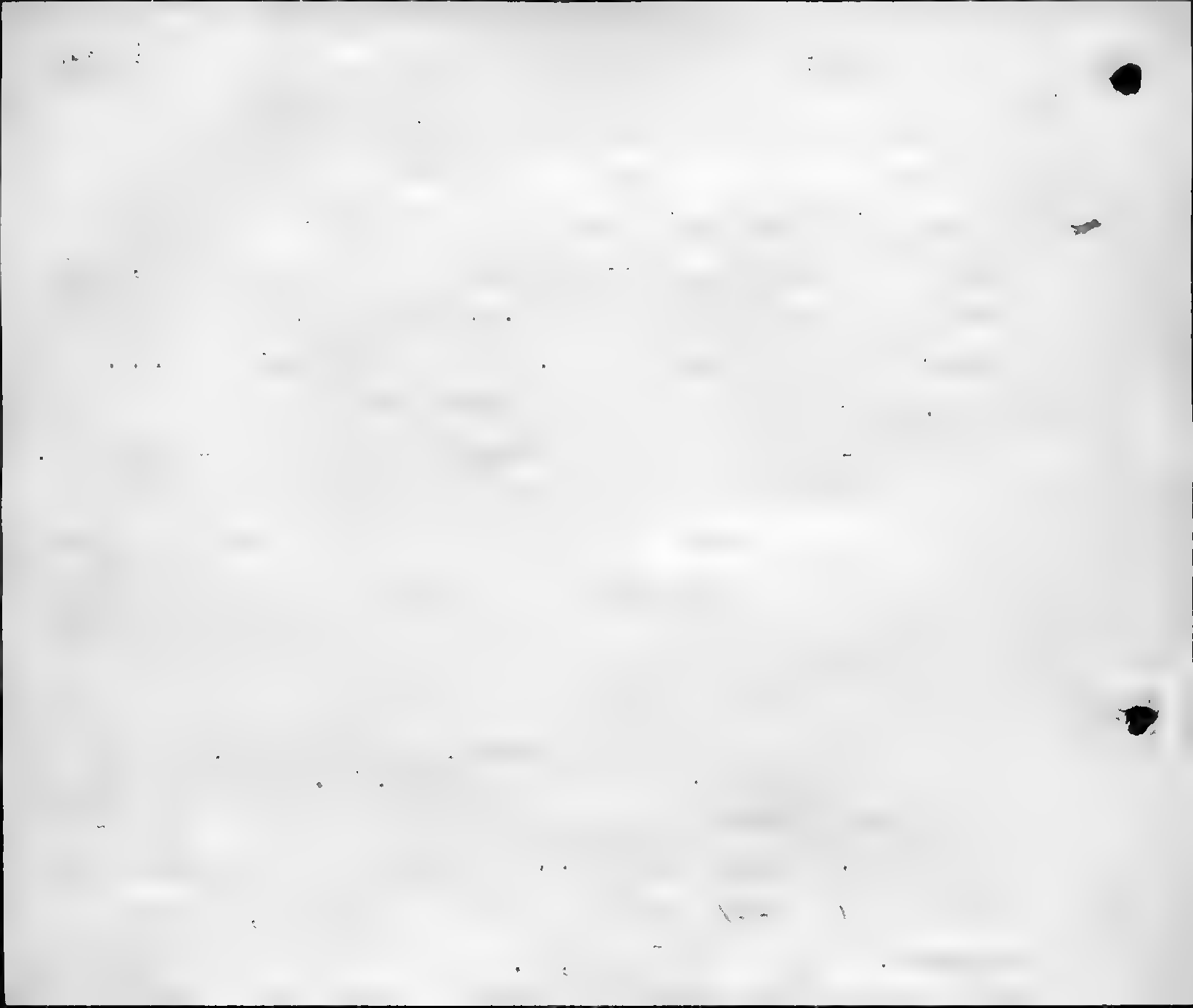


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2913 Item 14 Film G285 4/1/61 iwk 03907									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fort Howard		c. LENGTH OF STAY IN IS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Veterans Administration Hospital		40 Days		Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LYMAN		Middle		Last CARTER		4. DATE OF DEATH	
5. SEX		Male		6. COLOR OR RACE		Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		Feb. 2, 1889		9. AGE (In years last birthday)		72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country)		Drewrys Bluff, Virginia		12. CITIZEN OF WHAT COUNTRY?		U.S.A.		13. FATHER'S NAME	
Lee G. Carter		Harriet unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		WW-1		16. SOCIAL SECURITY NO.	
17. INFORMANT		Clinical Rec VAH Baltimore Md -Ft Howard Div.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		PNEUMONIA	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b)		CEREBRAL THROMBOSIS		(c)		GENERALIZED ARTERIOSCLEROSIS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY	
20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from March 7, 1961 to April 16, 1961 that (X) (we) last saw the deceased alive on April 16, 1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Charles E. Rowan		4-16-61		CHARLES E. ROWAN		M.D.		VAH Baltimore 18 Md -Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
Burial		4-20-61		Baltimore National		Baltimore, Maryland		25a. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR'S SIGNATURE		Arlington S. Phillips		25b. REGISTRAR'S SIGNATURE		Charles E. Rowan		DATE APR 18 '61	



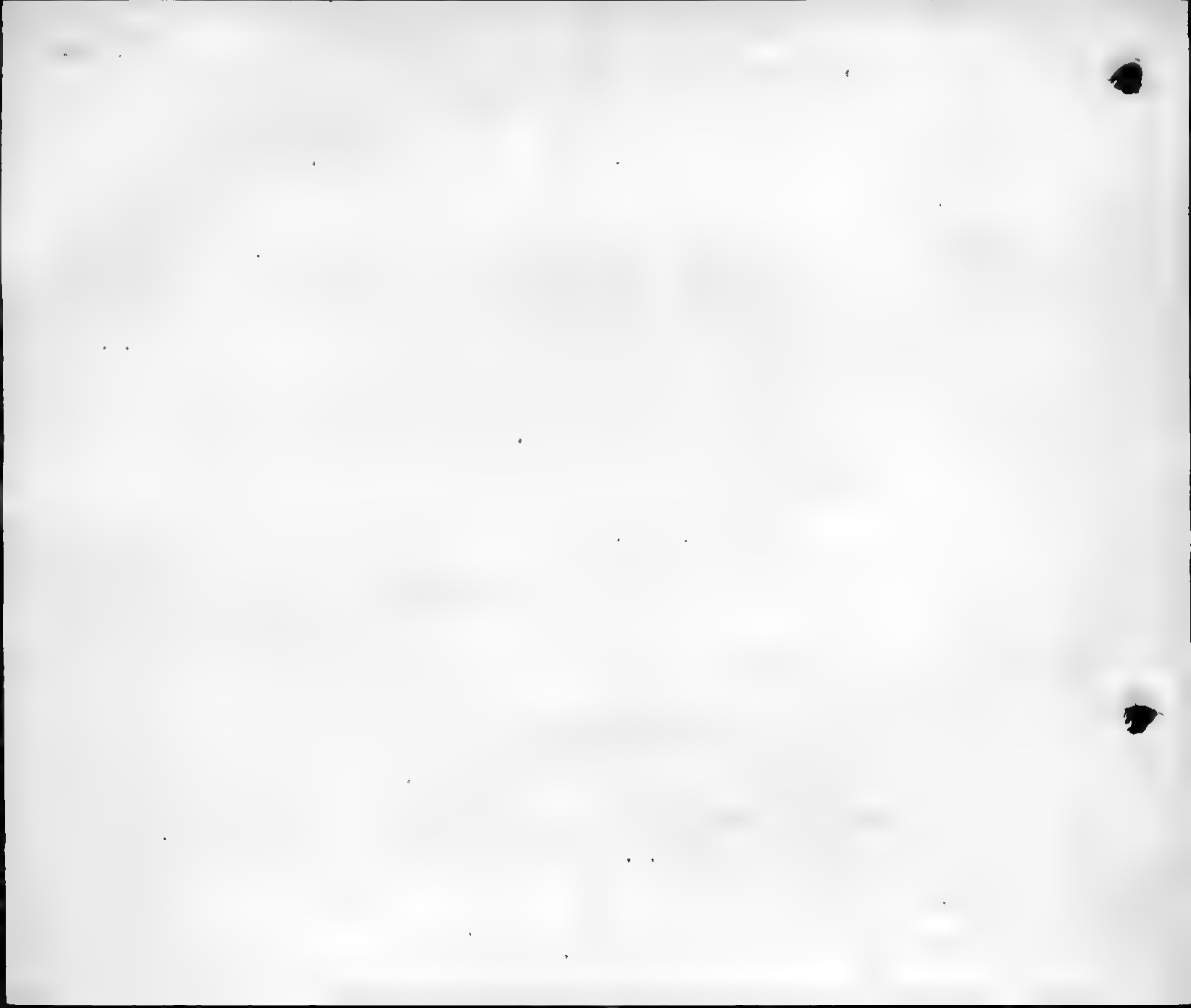
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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3914
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03908

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b 21 mos. plus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tacom Park, Md.	
3. NAME OF DECEASED (Type or print) First Mary Middle Belia Last Chick		4. DATE OF DEATH Month April Day 19 Year 1961	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/77
9. AGE (In years last birthday) 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Records: SPRING GROVE STATE HOSPITAL	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 9, 1960 to April 19, 1961 , that (I) (we) last saw the deceased alive on April 19, 1961 and that death occurred at 11:58 P. M. from the causes and on the date stated above			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville 28, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF April 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY West View Cemetery		23d. LOCATION (City, town or county) (State) Farmville Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Doyle & Burger		25a. REC'D BY REGISTRAR Farmville Va.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE APR 24 '61	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

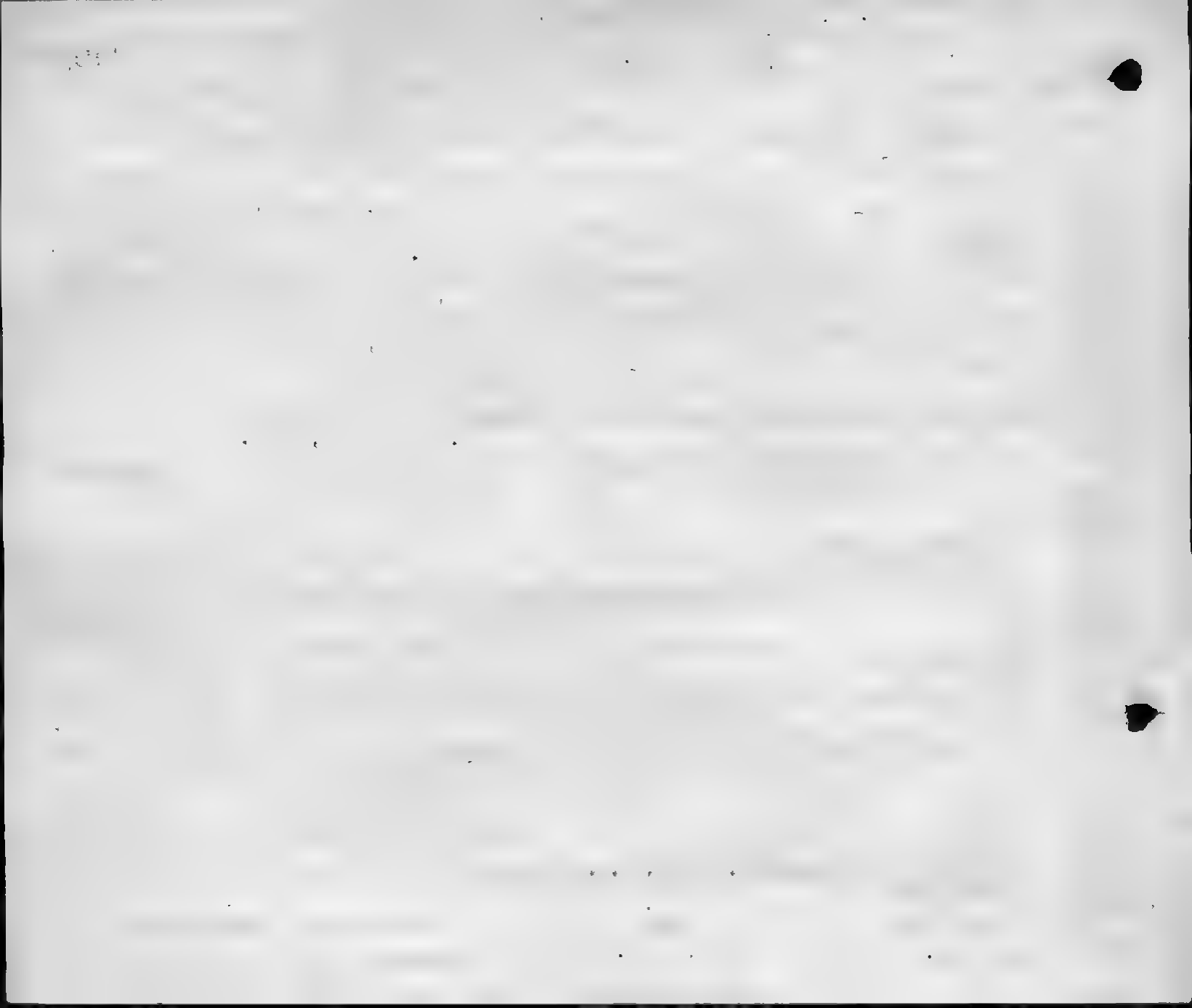
03909

Items 18-21, File 9-287 5/15/61.cac

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6609-C Glenbar Court		e. STREET ADDRESS 6609-C Glenbar Court		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS WEST CLAGGETT, Jr.		4. DATE OF DEATH Month Day Year April 28 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1910		9. AGE (In years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas West Claggett				14. MOTHER'S MAIDEN NAME Edna Starr					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or dates of service)		17. INFORMANT Thomas W. Claggett, 3rd. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 888.0 IMMEDIATE CAUSE (a) Ethyl Alcohol and Barbiturate Intoxication DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingestion of ethyl alcohol and barbiturates.							
20c. TIME OF INJURY Month, Day, Year Hour 3:36 p.m. 4/27/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Parkville, Baltimore, Md.		20g. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		DATE SIGNED 4/28/61		Address (Street, city, town, or county) Petersville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-61		22c. NAME OF CEMETERY OR CREMATORY St. Marks Church		22d. LOCATION (City, town, or country) Petersville, Maryland		(State)	
23. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc. 1900 Eutaw Place				ADDRESS		24a. REC'D BY REGISTRAR MAY 2 '61		24b. REGISTRAR'S SIGNATURE Carlton S. Thomas	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2016

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

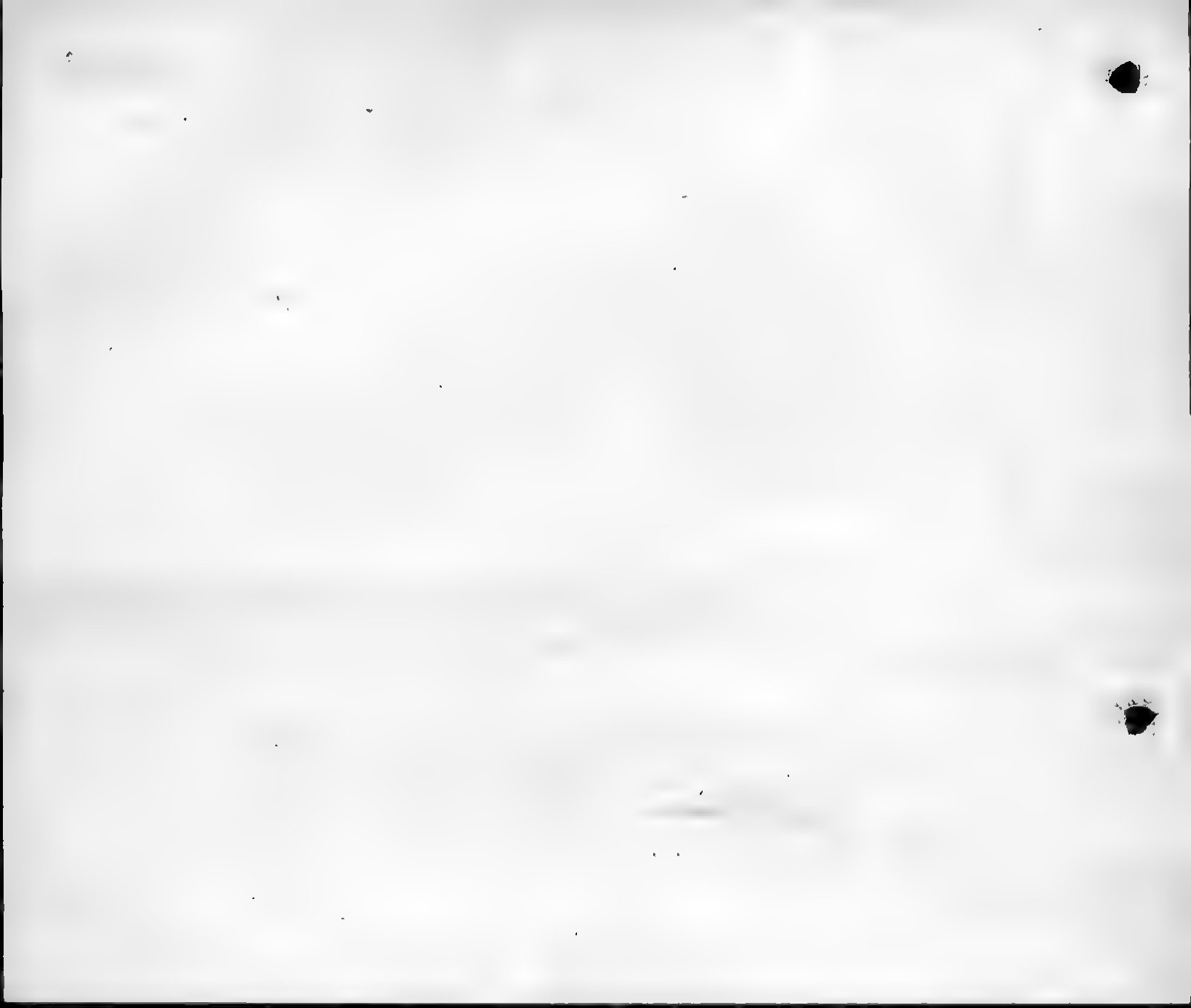
03910

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4013 Ridgewood Avenue	
3. NAME OF DECEASED (Type or print) First Manuel Middle Colvin Last Colvin		4. DATE OF DEATH Month April Day 28 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/09
9. AGE (In years lost birth day) 51 yrs		10. IF UNDER 1 YEAR Months 51 Days 18 Hours 15 Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joshua Colvin		14. MOTHER'S MAIDEN NAME Anna Rosen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Alzheimer's Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/21/61 to April 28 , 19 61 that (I) (we) last saw the deceased alive on April 28 , 19 61 , and that death occurred at 4:15 P. M. from the causes and on the date stated above			
22a. SIGNATURE Loretta Hsu		22b. DATE April 28, 1961	
22c. PHYSICIAN'S NAME (Type) Loretta Hsu M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville 28, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-30-61	
23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION (City, town, or county) (State) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		25a. REC'D BY REGISTRAR MAY 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. ADDRESS 2100 Bristow Place	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

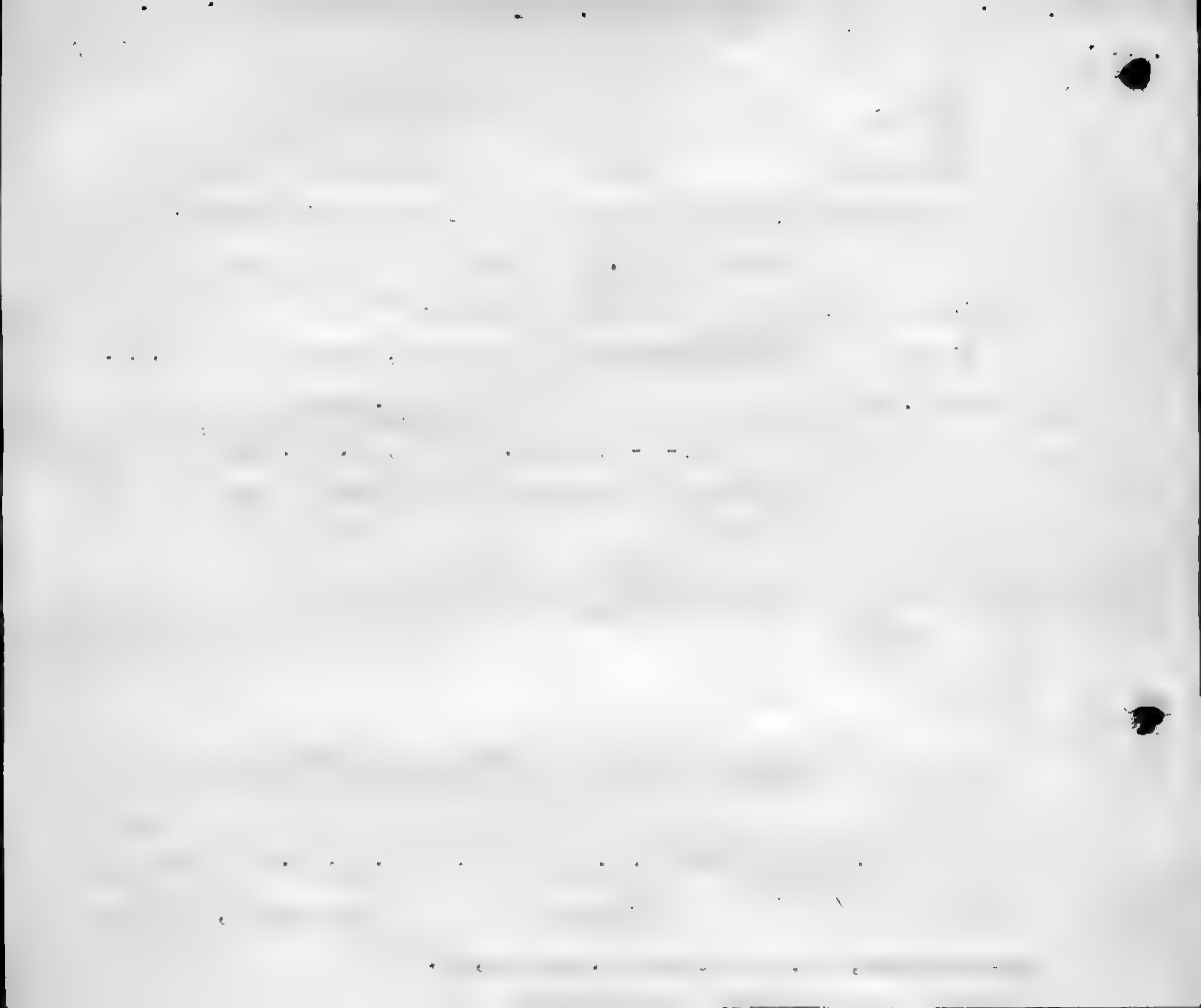
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3917

CERTIFICATE OF DEATH

03911

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 628 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 3438 Park Heights Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William H. Cook		4. DATE OF DEATH April 22 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 15, 1893		9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting Contractor		11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME John W. Cook		14. MOTHER'S MAIDEN NAME Mary B. Akers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give service) Yes WW I		16. SOCIAL SECURITY NO. 213-12-4374		17. INFORMANT Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md. Ft. Howard Division					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c) METASTATIC CARCINOMA DUE TO CARCINOMA OF COLON		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 8 YEARS		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>		20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State) Baltimore 18, Md. Ft. Howard Division			
21. I certify that (If this hospital) attended the deceased from August 3, 19 59 to April 22, 19 61 , that (we) last saw the deceased alive on April 22, 19 61 , and that death occurred 10:20 AM from the causes and on the date stated above.		22a. SIGNATURE M. Lawrence Rubin, M.D.		22b. DATE SIGNED 4/22/61		22c. PHYSICIAN'S NAME (Type) M. LAWRENCE RUBIN, M. D.		22d. ADDRESS VAH, BALTO. 18, MD. FT HOWARD DIVISION		22e. REC'D BY REGISTRAR APR 25 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Fries		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight, Ind. 6009 Harford Rd. Balto 14, Md.		24a. ADDRESS 6009 Harford Rd. Balto 14, Md.		24b. REC'D BY REGISTRAR APR 25 '61		24c. REGISTRAR'S SIGNATURE Arthur S. Fries		24d. REC'D BY REGISTRAR APR 25 '61		24e. REGISTRAR'S SIGNATURE Arthur S. Fries		24f. REC'D BY REGISTRAR APR 25 '61		24g. REGISTRAR'S SIGNATURE Arthur S. Fries		24h. REC'D BY REGISTRAR APR 25 '61		24i. REGISTRAR'S SIGNATURE Arthur S. Fries			



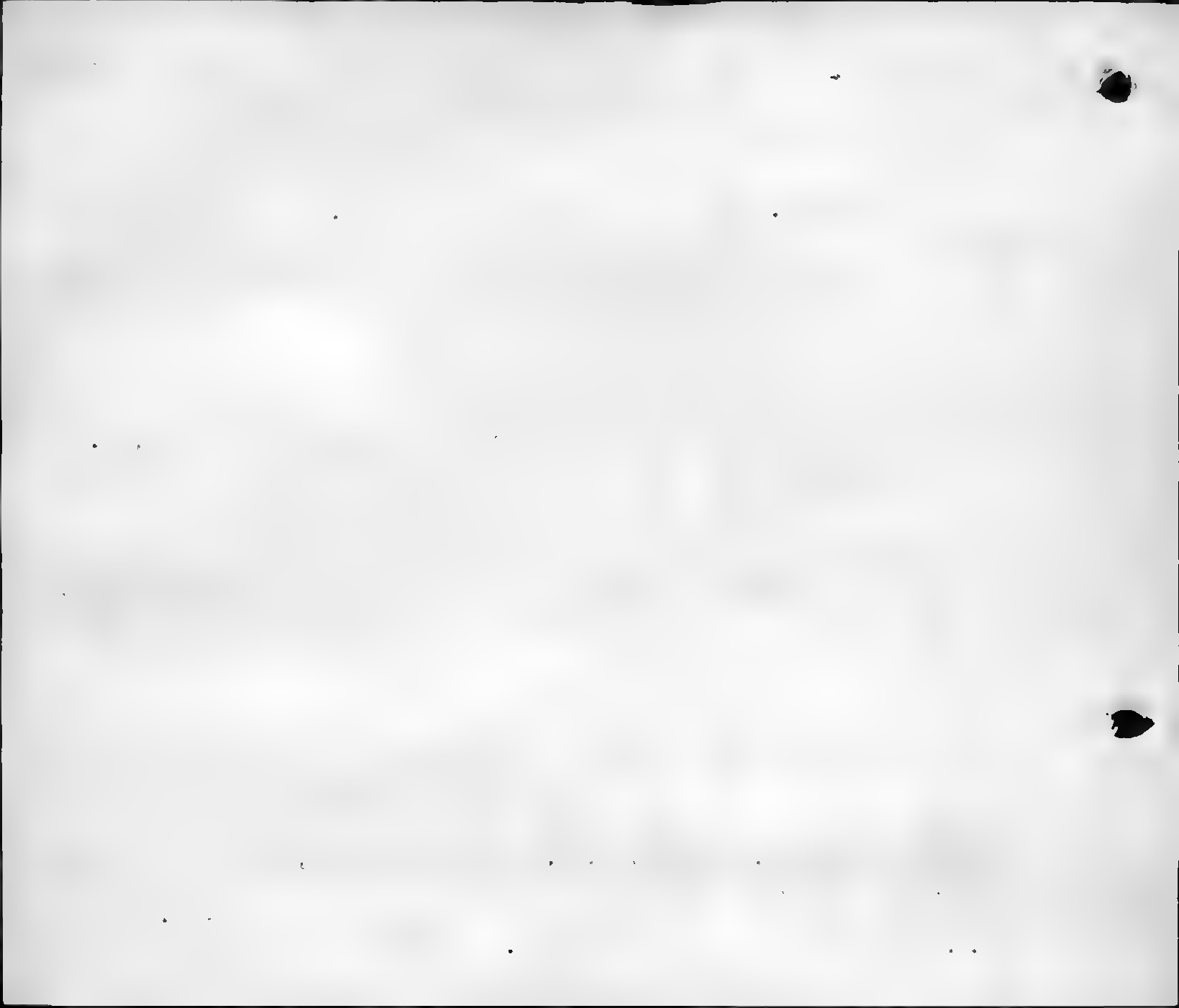
CERTIFICATE OF DEATH

Reg. Dist. No. 03912

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 80 Frederick Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle CLARENCE Last CORUN				4. DATE OF DEATH Month April Day 21 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8 1878	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 2 Days 12 Hours 0 Min.		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? Virginia	
13. FATHER'S NAME Albert Corun				14. MOTHER'S MAIDEN NAME Jennie Beach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 218-05-3297		17. INFORMANT Paul Corun New Cut Rd, Ellicott City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitotic Carcinoma, Cecum 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 1 19 58 , to Apr 21 19 61 , that I last saw the deceased alive on Apr 3 19 61 , and that death occurred at 10:00 p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 46 Church Road DATE SIGNED 4-22-61							
ACTUAL SIGNATURE Thomas F. Herbert M.D.				DATE SIGNED 4-22-61			
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M. D. Ellicott City, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/61		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham				24a. REC'D BY REGISTRAR APR 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

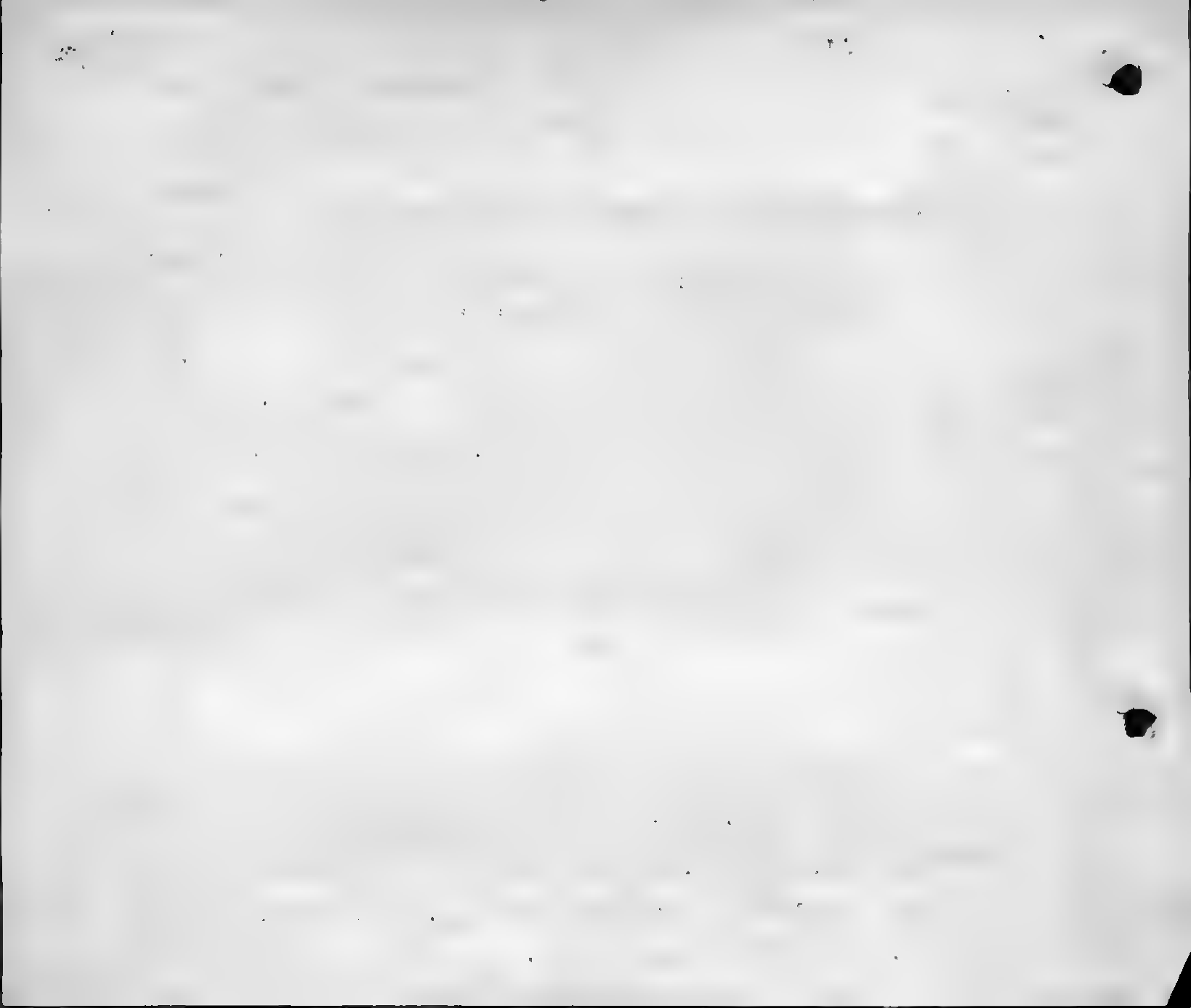
V5. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		Baltimore		a. STATE		Md	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Lansdowne		b. COUNTY		Balto	
c. LENGTH OF STAY IN TB		Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Lansdowne	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
XXXXXXXXXXXX 103 Second Avenue				XXXXXXXXXXXX 103 Second Avenue			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
James Joseph Snider				April 17, 1961			
5. SEX				6. COLOR OR RACE			
Male				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				April 2, 1901			
9. AGE (In years last birthday)				10. BIRTHPLACE (State or foreign country)			
70 yrs.				Penna			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY?			
Home duties				U.S.A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Albert J. Snider				Ann Snider			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
no				one			
17. INFORMANT				Address			
Joseph W. Gayle 103 2nd Ave. 27							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 0 (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
DATE SIGNED April 17, 1961							
Address (Street, city, town, or county)							
21a. BURIAL, CREMATION, REMOVAL (Specify)							
Burial							
21b. DATE THEREOF 4/21/61							
21c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.							
21d. LOCATION (City, town, or county) Baltimore, Maryland							
23. FUNERAL DIRECTOR ADDRESS							
Howard H. Hubbard 4107 Wilkens Ave.							
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE							
DATE APR 24 '61 Arthur S. Kline							

(M)

(I)



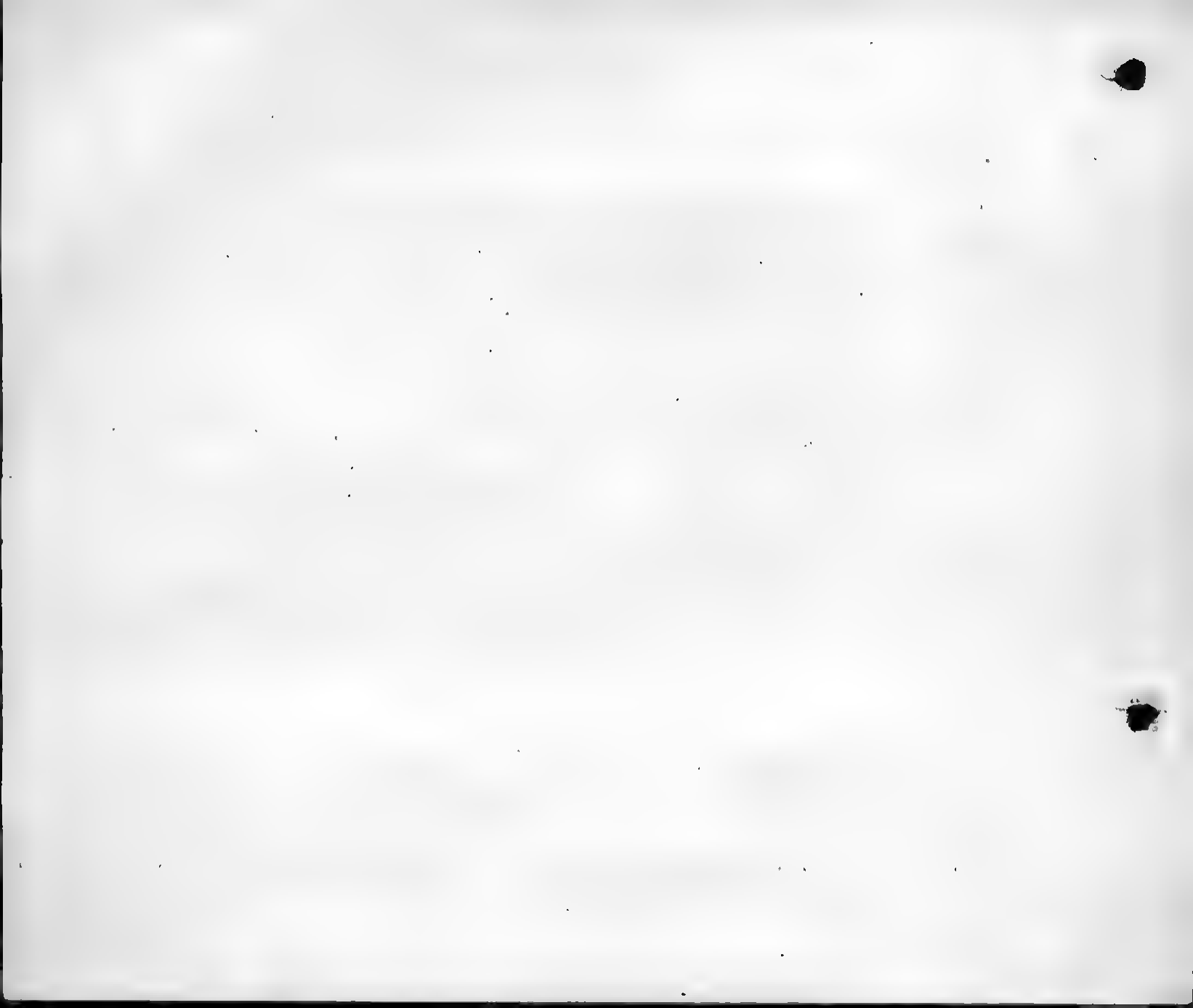
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3520
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03914

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 23 hours d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS d. STREET ADDRESS 26 BUNCHE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH WESTLY CULLEY		4. DATE OF DEATH Month Day Year APRIL 6 1961	
5. SEX M	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/1912
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS CULLEY		14. MOTHER'S MAIDEN NAME ELIZABETH TURNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 9/28/42-6/24/45		16. SOCIAL SECURITY NO 220-01-5912	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163 X DUE TO Carcinoma of the Lung with Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH approximately 15 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 4/5/1961 to 4/6/1961, that (we) last saw the deceased alive on 4/6/1961, and that death occurred at 10:28 AM, from the causes and on the date stated above			
22a. SIGNATURE W. Newcanner		22b. DATE SIGNED 4/6/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcanner, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-1961	
23c. NAME OF CEMETERY OR PREMATORY National		23d. LOCATION (City, town, or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. J. ...		25a. REC'D BY REGISTRAR DATE APR 12 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraw...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3921											
CERTIFICATE OF DEATH											
03915											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u>					
c. LENGTH OF STAY IN 1b <u>30 yrs</u>						d. STREET ADDRESS <u>1728 Arlington ave</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1728 Arlington ave</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BERNADETTE M. CURRAN</u>						4. DATE OF DEATH <u>April 16 1961</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Nov. 10, 1874</u>					
9. AGE (In years last birthday) <u>86</u> yrs						10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>						11. BIRTHPLACE (County & State or foreign country) <u>Baltimore</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Joseph A. Curran</u>					
14. MOTHER'S MAIDEN NAME <u>Elizabeth V. Williamson</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give number and date of service)					
16. SOCIAL SECURITY NO. <u>no</u>						17. INFORMANT <u>Mr. Joseph J. Curran</u> Address <u>Same</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary disease - mycorotus -</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arterio sclerosis -</u>											
(c) <u>Acute decompensation</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1936</u> to <u>April 16 1961</u> , that (I) (we) last saw the deceased alive on <u>April 16 1961</u> , and that death occurred at <u>1728 Arlington ave</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Frederic V. Bentler</u> M.D.						22b. DATE SIGNED <u>APR 19 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>FREDERIC V. BENTLER</u>						22d. ADDRESS <u>1014 Francis Ave - Baltimore</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 19, 1961</u>						23b. DATE THEREOF <u>April 19, 1961</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>						23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Son Co.</u>						25a. RECEIVED BY REGISTRAR <u>Henry W. Jenkins & Son Co.</u>					
25b. REGISTRAR'S SIGNATURE <u>Henry W. Jenkins & Son Co.</u>						25c. DATE <u>APR 19 1961</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

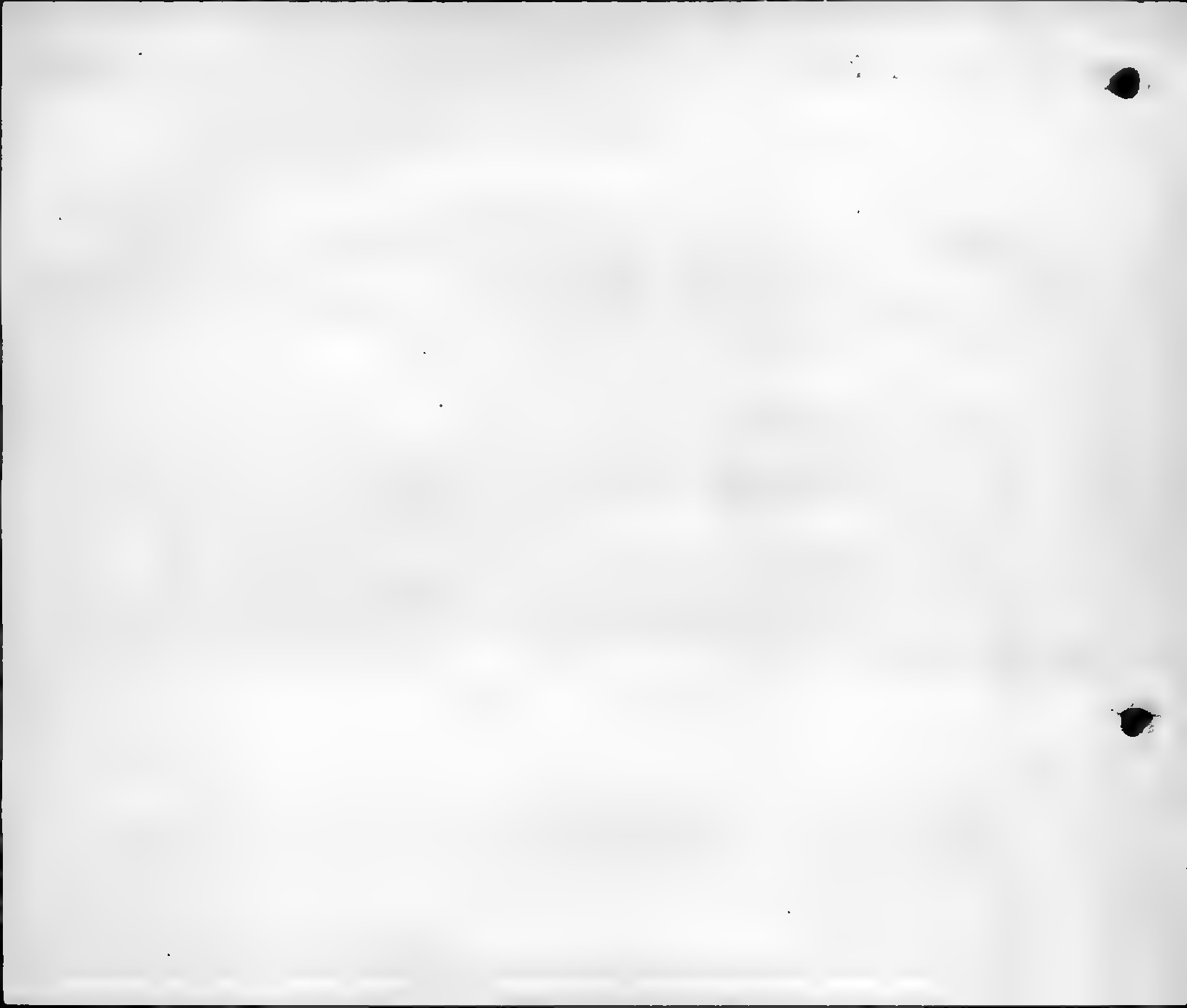
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, F-10 G-84 4/5/61 jwk

CERTIFICATE OF DEATH

Reg. Dist. No. 03916

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Washington</u>			
c. LENGTH OF STAY IN 1b <u>1 week</u>				d. STREET ADDRESS <u>3626 Whitehaven Pkwy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2312 Springlake Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>M.</u> Last <u>Dailey</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1 1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Andrew J. May</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Arthur W. Danglin 2312 Springlake Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u>							
DUE TO (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastatic carcinoma of liver.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-31, 1961</u> , to <u>4-4, 1961</u> , that I last saw the deceased alive on <u>4-3, 1961</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John J. Gould</u> M.D. <u>2308 Pot Springs Rd. Tim. 4-461</u>				PHYSICIAN'S NAME (Type) <u>JOHN J. GOULD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON - VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. COOK-TOWSON INC - 1650 YORK RD. TOWSON</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>W. A. COOK</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03917

2023

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b Most of Life	
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION Hollow Road, Cockeysville, Md		d. STREET ADDRESS / Hollow Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Granville First Dawson Middle Last		4. DATE OF DEATH April Month 29 Day 1961 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1908
9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Metro.	11 BIRTHPLACE (State or foreign country) West Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Dawson		14. MOTHER'S MAIDEN NAME Blanche ?	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 232-26-5843	
17 INFORMANT Mrs J. Howard Hollow Rd Cockeysville		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Coronary sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 1 m McDieter 17 yrs.
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from July 19 60 , to April 19 61 , that (I) (we) last saw the deceased alive on April 12 1961 and that death occurred at 6:35 PM from the causes and on the date stated above			
22a SIGNATURE Elizabeth B. Sherrill M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill		22d. ADDRESS Cockeysville, Md.	
23a BUR A. CREMATION, REMOVAL (Specify) Buried	23b DATE THEREOF 5-2-61	23c. NAME OF CEMETERY OR CREMATORY Mays Chapel Cemetery	23d LOCATION (City, town, or county) (State) Cockeysville Md.
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md.		25a REC'D BY REGISTRAR DATE MAY 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

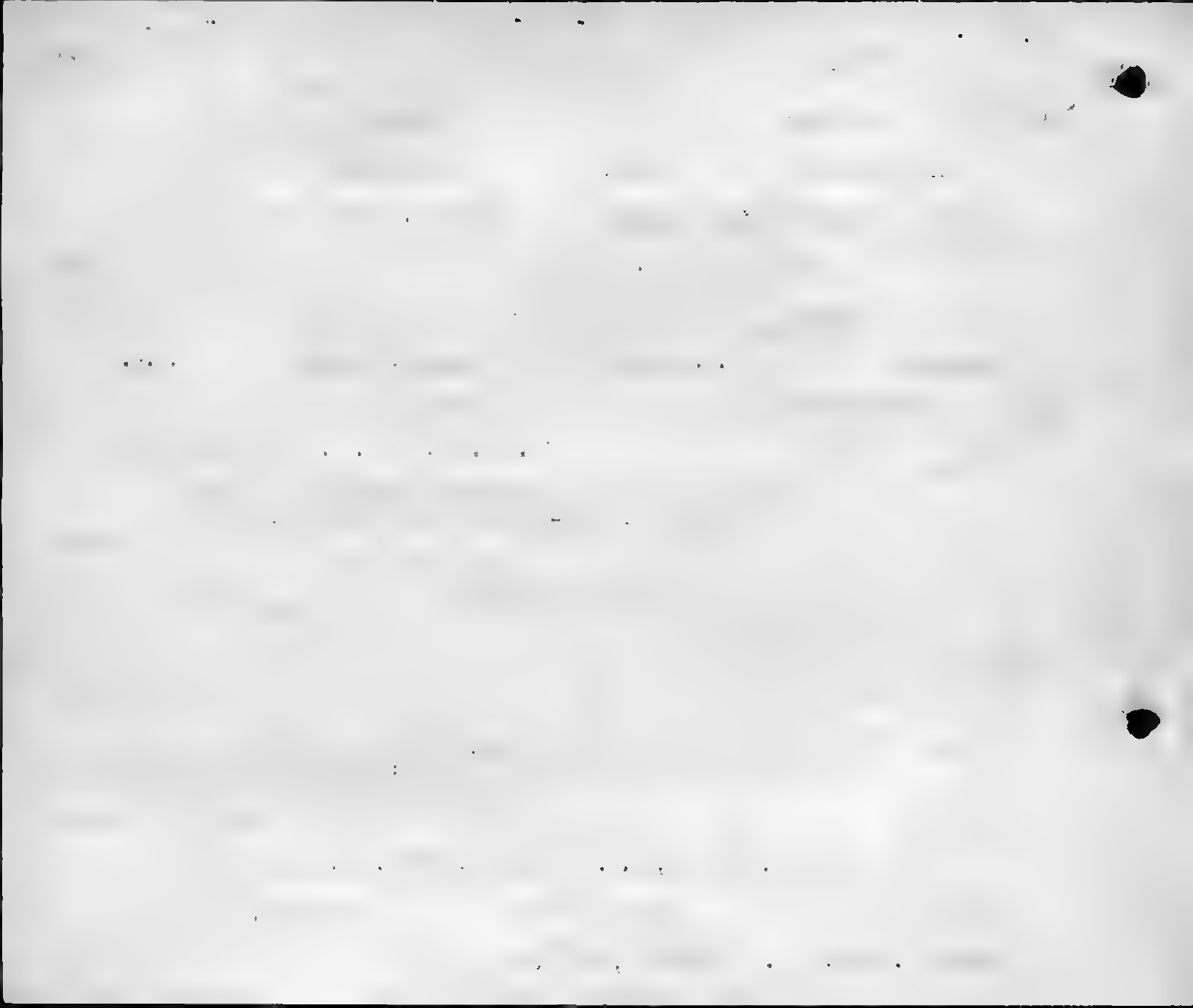
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3924

03918

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY (In days) 30 Days		d. STREET ADDRESS 2905 St. Paul Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUIS W. DEHLER	4. DATE OF DEATH APRIL 29 19 61	5. SEX Male 6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 8/30/87	9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adam Dehler	14. MOTHER'S M A D E N NAME MARY (UNKNOWN)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. WW I			
17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH WITH METASTASES TO LIVER PANCREAS, GALL-BLADDER, LUNGS AND MEDIASTINAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XX PANCREAS, GALL-BLADDER, LUNGS AND MEDIASTINAL XX NODES DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POLYCYSTIC KIDNEYS 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part I. of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from March 30, 1961 to April 29, 1961 that (he) (we) last saw the deceased alive on April 29, 1961 , and that death occurred at 11:20 PM , from the causes and on the date stated above 22a. SIGNATURE Donald W. Stewart 22b. DATE SIGNED 4/30/61 22c. PHYSICIAN'S NAME (Type) DONALD W. STEWART, M.D. 22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION 22e. REC'D BY REGISTRAR MAY 4 '61 22f. REGISTRAR'S SIGNATURE Arthur S. Kline 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-3-61 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. ADDRESS 5305 Harford Road Baltimore, Maryland			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/69

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03919											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Res. date before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tel, give street address) <i>393 Butter Rd.</i>				d. STREET ADDRESS <i>395 Butter Rd.</i>							
3. NAME OF DECEASED (Type or print) <i>DOUGLAS GREG DELBAUGH</i>				4. DATE OF DEATH Month <i>Apr</i> Day <i>17</i> Year <i>1961</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 15 1900</i>		9. AGE (in years last birthday) yrs. <i>4</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>4</i> Days <i>17</i> Hours <i>17</i> Mins. <i>17</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>				11. BIRTHPLACE (State or foreign country) <i>Hunterdon, Pa.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>											
13. FATHER'S NAME <i>Wm. F. Delbaugh</i>				14. MOTHER'S MAIDEN NAME <i>Dorothy Atkinson</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>				17. INFORMANT <i>Dr. Dorothy Delbaugh - Reisterstown</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>											
493X DUE TO											
Conditions, if any, which gave rise to immediate cause (b) <i>None</i>											
(c) DUE TO											
(e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Congenital deformity Rt. side of nose</i>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>None</i>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>None</i> p.m. <i>None</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>D.D. Caples</i>				M.D. ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>4-17-61</i>			
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>April 19, 1961</i>				22c. NAME OF CEMETERY OR CREMATORY <i>West Side Cemetery</i>			
22d. LOCATION (City, town, or county) (State) <i>Shomokin Dam, Pa.</i>											
23. FUNERAL DIRECTOR <i>J.F. Fline & Sons, Reisterstown, Md.</i>				ADDRESS				24a. REC'D BY REGISTRAR <i>APR 19 '61</i>			
24b. REGISTRAR'S SIGNATURE <i>Charles S. Fline</i>											

4 VVVVVVV XVV



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

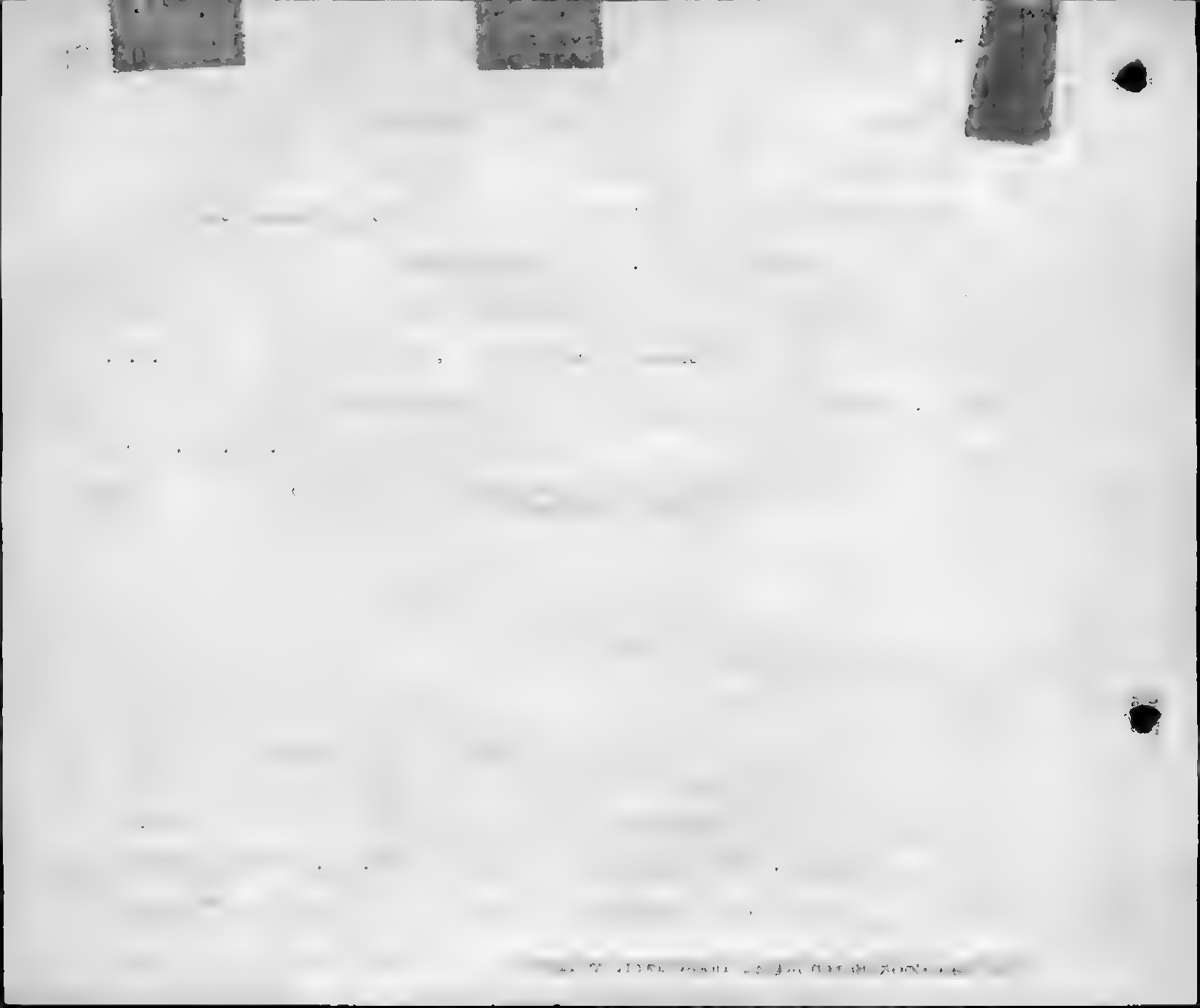
3326

03920

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN It <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>753 West Baltimore Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADEN M. DELLINGER</u>		4. DATE OF DEATH Month Day Year <u>April 14 19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>April 18, 1896</u>		9. AGE (In years, last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Garage Mount Jackson, Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Dellinger</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Lee Grim</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Clin Records, VAH, Balto. Md. Ft. Howard, Div.</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TUBERCULOSIS OF THE LUNG, FAR ADVANCED,</u> DUE TO _____ (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>April 10, 1961, to April 14, 1961</u> , that <u>X</u> (we) last saw the deceased alive on <u>April 14, 1961</u> , and that death occurred <u>1:40AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Crahan</u> M.D.		22b. DATE SIGNED <u>April 14, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M. D.</u>		22d. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-14-61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Massanutten Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodstock, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Blight Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 17 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>		25c. ADDRESS <u>Baltimore, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3927

03921

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashland c. LENGTH OF STAY IN (b) MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ashland Road				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashland d. STREET ADDRESS Ashland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRISON GILMORE DENMYER		4. DATE OF DEATH Month April Day 26 Year 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 12, 1887			
9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months 7 Days 4 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-retired		10b. KIND OF BUSINESS OR INDUSTRY General labor			
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 218-10-5308 17. INFORMANT Family records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Chronic (b) Myocardial Infarction (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 1 p.m. 3		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Reisterstown (County) MD (State)		21. I certify that (I) (this hospital) attended the deceased from 4-26-61 to 4-26-61 19 that (I) (we) last saw the deceased alive on 4-26-61 19 and that death occurred at 4-26-61 from the causes and on the date stated above.					
22a. SIGNATURE James G. Saffell 22c. PHYSICIAN'S NAME (Type) James G. Saffell		22b. DATE SIGNED 4-29-61 22d. ADDRESS Reisterstown		22e. DATE SIGNED 4-29-61 22f. ADDRESS Reisterstown			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 29, 1961		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery			
23d. LOCATION (City, town or county) Parkville, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland					
25a. REC'D BY REGISTRAR MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kneass					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3923

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03922

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1404 E. JOPPA ROAD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>1404 E. JOPPA ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>PAUL MONETT DENTON</u>		4. DATE OF DEATH <u>APRIL 5, 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 10, 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES TRAINING MGR. CON. CAN CO.</u>		9. AGE (In years last birthday) <u>50 yrs.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN F. DENTON</u>		14. MOTHER'S MAIDEN NAME <u>ROBERTA LUSBY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>FAMILY RECORDS</u>	
17. INFORMATION <u>FAMILY RECORDS</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>18 years 8</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>February 27 1945</u> to <u>April 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 1, 1961</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Grafton Hersperger</u>		22b. DATE SIGNED <u>April 5, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. GRAFTON HERSPERGER</u>		22d. ADDRESS <u>214 Medical Arts Building</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-8-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM. PARK</u>		23d. LOCATION (City, town or county) <u>PARKVILLE, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u>		25a. REC'D BY REGISTRAR <u>APR 10 '61</u>	
ADDRESS <u>Towson 4 Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03923

2020

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 8yr7mth16dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lena Middle Ann Last DePro				4. DATE OF DEATH Month April Day 22 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1876		9. AGE (in years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 22 Days 19 Hours 61	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Johnson				14. MOTHER'S MAIDEN NAME Elizabeth Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterine cervix							
DUE TO (b) _____							
Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last.							
DUE TO (c) Chronic Brain Syndrome, associated with generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
Chronic Brain Syndrome Assoc. with Generalized Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1960 to April 22, 1960 , that (I) (we) last saw the deceased alive on April 22, 1961 , and that death occurred 4:14 PM from the causes and on the date stated above.							
22a. SIGNATURE Jose R. Arizaga M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED April 22, 1961	
22c. PHYSICIAN'S NAME (Type) Jose R. Arizaga, M.D.				22d. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/26/61		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION (City, town, or county) Balto. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.				25a. REC'D BY REGISTRAR APR 25 '61		25b. REGISTRAR'S SIGNATURE Charles E. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3930

CERTIFICATE OF DEATH

Item 7, Film G 308

03924

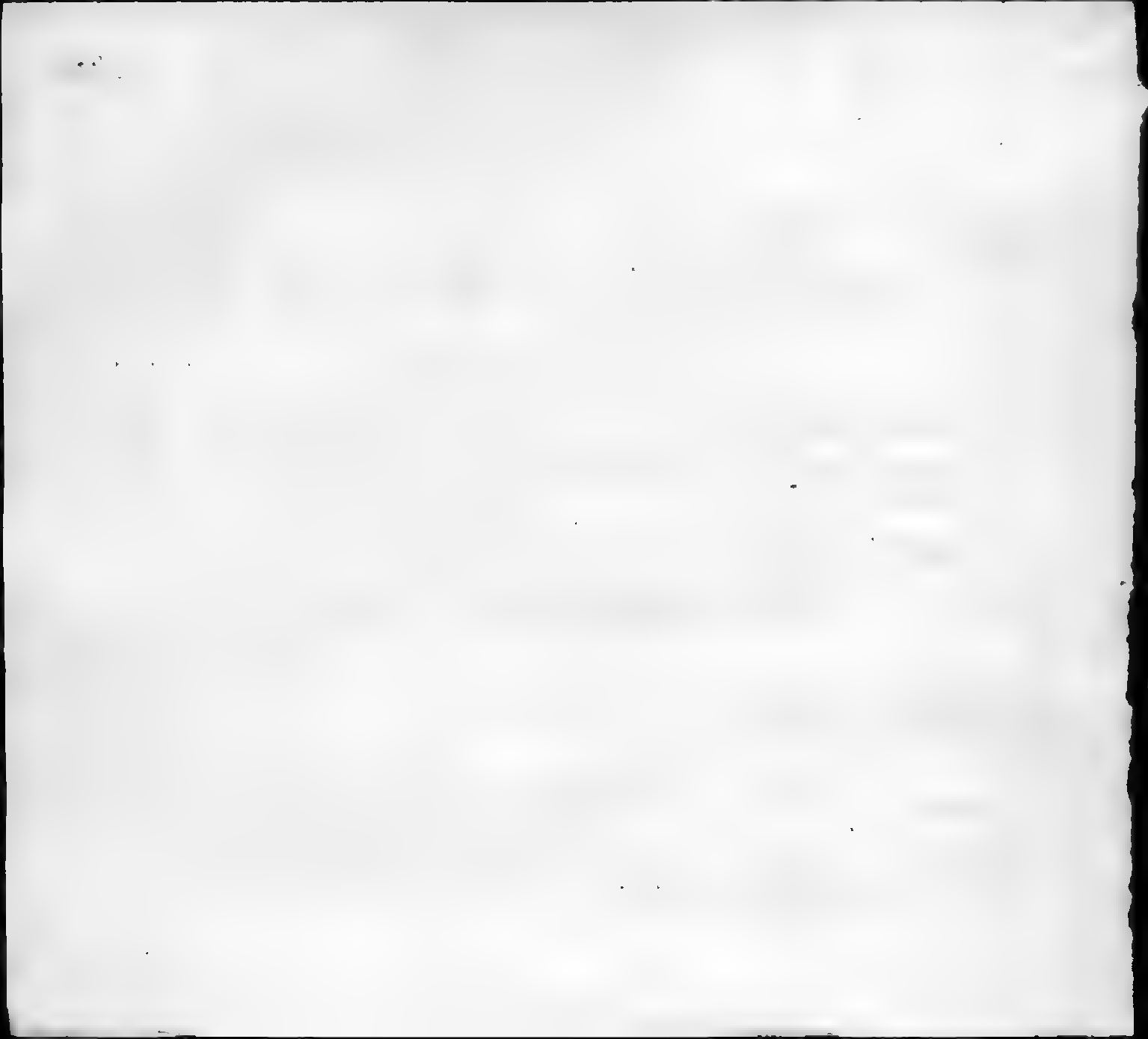
Item 9 Film G285

4/24/61 wk 3/12/62-1m1

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10yr9mth17dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 105 Fifth Street	
3. NAME OF DECEASED (Type or print) First William Middle P. Last DeWald		4. DATE OF DEATH Month April Day 6 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 26, 1909
		9. AGE (In years last birthday) 51 52 yrs	10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY contracting	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George G. DeWald		14. MOTHER'S MAIDEN NAME Bessie King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-05-9107	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 18, 1952 to April 6, 1961 that (I) (we) last saw the deceased alive on April 6, 1961 and that death occurred at 8:15 A. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 4-7-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF April 8, 1961	23c. NAME OF CEMETERY OR CREMATORY Long Hill Cemetery Laurel Md.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Edwitt Donaldson Laurel Md.		25a. REC'D BY REGISTRAR DATE APR 11 '61	
		25b. REGISTRAR'S SIGNATURE Vernon S. Kline	

MEDICAL CERTIFICATION

the State Board of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03925

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 2yrl4mth19dys		d. STREET ADDRESS unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Dolan Last Dolan		4. DATE OF DEATH Month April Day 28 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888?
9. AGE (In years last birthday) 72? yrs.		IF UNDER 1 YEAR Months 72 Days ? Hours ? Min. ?	IF UNDER 24 HRS. Hours ? Min. ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from December 9 19 58 to April 28 19 61 , that (I) (we) last saw the deceased alive on April 28 19 61 , and that death occurred at 12:20 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 5-2-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 5/3/61		23b. DATE THEREOF 5/3/61	
23c. NAME OF CEMETERY OR CREMATORY Cathedral		23d. LOCATION (City, town, or county) (State) 4300 Old Frederick	
24. FUNERAL DIRECTOR'S SIGNATURE G. J. Fickerson		25a. REC'D BY REGISTRAR DATE MAY 3 '61	
ADDRESS 1318 Light		25b. REGISTRAR'S SIGNATURE Arthur S. Fickerson	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital-attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03926

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN TB 13yr9mo +	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Yaggie Last Downey		4. DATE OF DEATH Month April Day 27 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Yagge		14. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Congestive heart failure DUE TO (c) arteriosclerotic cardiovascular disease with hypertension. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 23 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 4, 19 61 to April 27, 1961 , that (I) (we) last saw the deceased alive on April 26, 19 61 , and that death occurred at 6:11 from the causes and on the date stated above			
22a. SIGNATURE Aristides Simopoulos		22b. DATE SIGNED April 27, 1961	
22c. PHYSICIAN'S NAME (Type) Aristides Simopoulos		22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
25a. REC'D BY REGISTRAR DATE APR 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



2933

03922

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 Norris Lane				d. STREET ADDRESS 707 Norris Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID W. DUDLEY				4. DATE OF DEATH Month Day Year April 3, 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1901		9. AGE (in years last birthday) 59 yrs.	f. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Board of Education		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel I. Dudley				14. MOTHER'S MAIDEN NAME Mabel Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 111-12-4539		17. INFORMANT Ida Maye Dudley, S me			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-3-61 to 4-3-1961 , that (I) (we) last saw the deceased alive on 4-3-61 19____, and that death occurred at 8:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE John E. Gossner				22b. ADDRESS 701 Eastern Avenue Md.		22c. DATE 4-4-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/61		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James E. Truzewinski				25a. REC'D BY REGISTRAR DATE APR 5 '61		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2934

03928

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b. <u>Towson</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6511 Sherwood Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>6511 Sherwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUTH S EBERLING</u> First Middle Last 4. DATE OF DEATH <u>April 18 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 22, 1920</u> Yrs. <u>40</u>	
9. AGE (In years last birthday) <u>40</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u> 12. CITIZEN OF WHAT COUNTRY? <u>Same</u>		13. FATHER'S NAME <u>George S. Sawyer</u> 14. MOTHER'S MAIDEN NAME <u>Annie L. Ashbourne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>Robert C. Eberling</u> 17. INFORMANT <u>Same</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GRAVIDITY 2-3 CARCINOMATOSIS</u> DUE TO (b) <u>FROM CARCINOMA OF LEFT BREAST</u> DUE TO (c) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>2 yr</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 23, 1948</u> , to <u>April 18, 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 18, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry J. Genbino</u> M.D. 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7215 York Rd Baltimore 12, MD</u> 22b. DATE SIGNED <u>April 19, 1961</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u> 23b. DATE THEREOF <u>April 21, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Woodlawn Balto. Co, Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Genbino & Sons, Co.</u> ADDRESS <u>4905 York Road</u> 25a. REC'D BY REGISTRAR <u>APR 19 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Hinkle</u>	

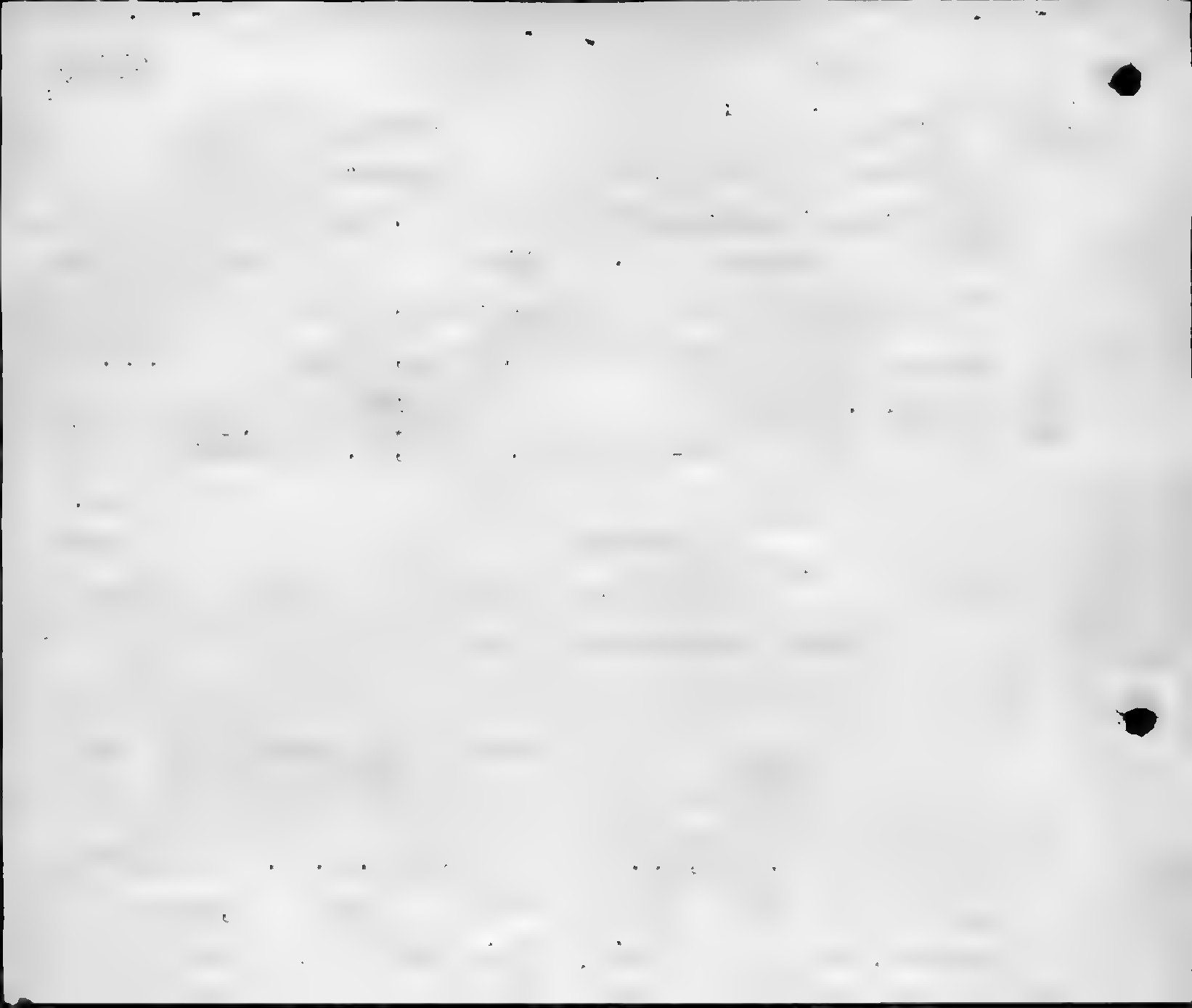


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2035											
CERTIFICATE OF DEATH											
03929											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 10 N. Monroe Street							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 135 days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				f. DATE OF DEATH Last First Middle April 20 19 61				g. AGE (In years last birthday) yrs. Months Days 39			
3. NAME OF DECEASED (Type or print) Alexander N. Edemy				5. SEX Male				6. COLOR OR RACE Negro			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH September 13, 1921				9. AGE (In years last birthday) yrs. Months Days 39			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Restaurant				11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland			
13. FATHER'S NAME Alexander N. Edemy				14. MOTHER'S MAIDEN NAME Maude Fisher				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes WW II				16. SOCIAL SECURITY NO. 216-14-5482				17. INFORMANT Clin. Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md. Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) COR PULMONALE (c) SARCOIDOSIS, PULMONARY				INTERVAL BETWEEN ONSET AND DEATH 10 min. 7 years 7 years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Monilia Infection, Gastric Ulcer				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from December 6, 1960 , to April 20, 1961 , that (we) last saw the deceased alive on April 20, 1961 , and that death occurred at 10:00PM from the causes and on the date stated above.				22a. SIGNATURE Joseph J. Cillo M.D.				22b. DATE SIGNED 4/23/61			
22c. PHYSICIAN'S NAME (Type) JOSEPH J. CILLO, M.D.				22d. ADDRESS VAH, Balto. Md. Ft. Howard Division				22e. DATE SIGNED 4/23/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-25-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				24b. ADDRESS 1800 N. Monroe St. Baltimore, Maryland				25a. REC'D BY REGISTRAR APR 26 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Hines				25c. LOCATION (City, town or county) (State) Baltimore 28, Maryland				25d. DATE SIGNED APR 26 '61			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

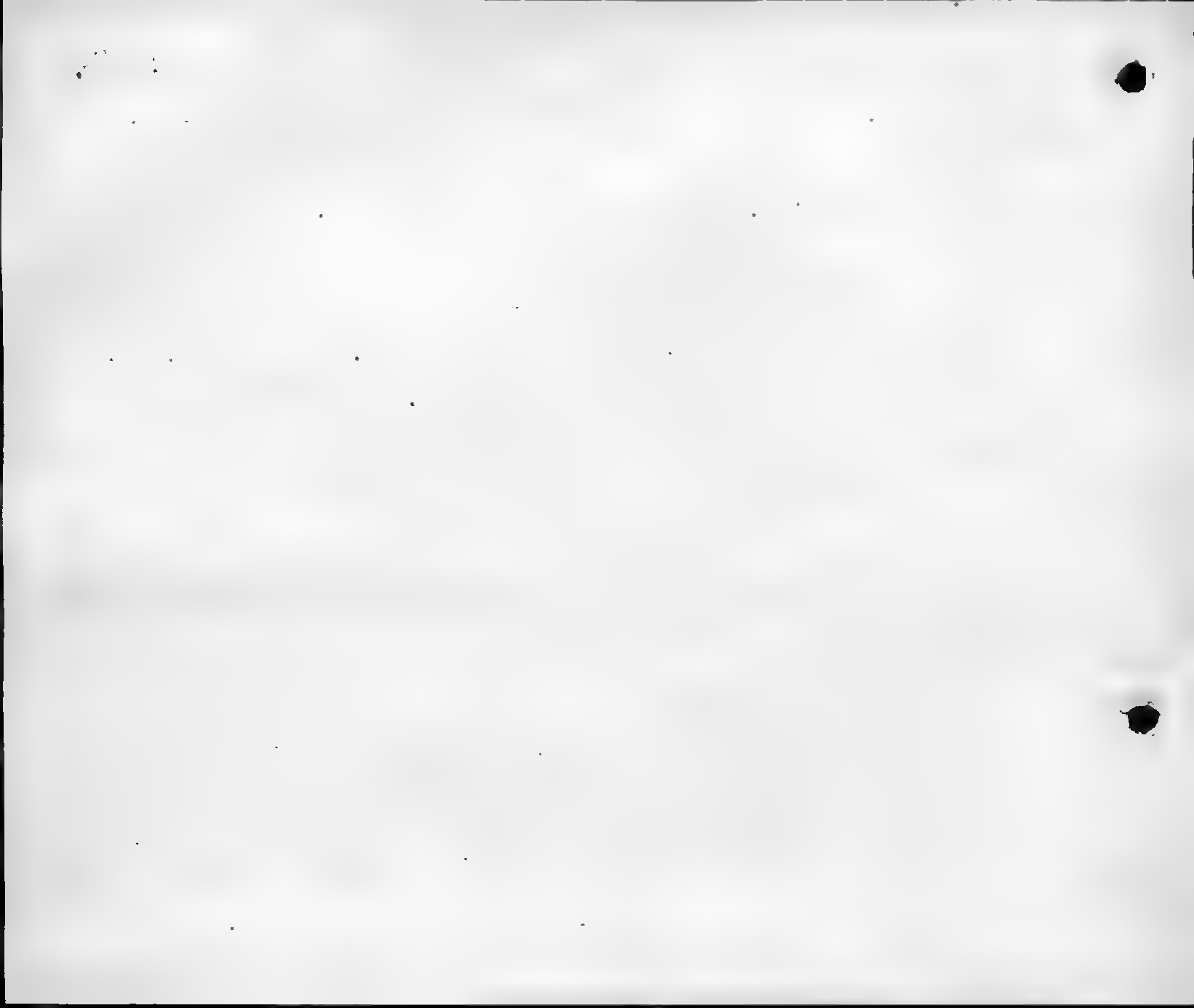
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2936

03930

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowelys Quarters</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2019 Oakland Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Veirs Edwards</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1884</u>
9. AGE (In years last birthday) yrs <u>76</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Biddison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Anna Ricords</u>		Address <u>2019 Oakland Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF</u> <u>177X</u> DUE TO (b) <u>PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1, 1951</u> to <u>APR. 22 1961</u> , that (I) (we) last saw the deceased alive on <u>APR 21 1961</u> , and that death occurred at <u>4:15 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Miceli</u> M.D.		22b. DATE <u>4/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>		22d. ADDRESS <u>108 S. TAYLOR AVE BALTO MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-25-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Orems Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lester J. Smith</u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>C. S. Thomas</u>		25c. ADDRESS <u> </u>	

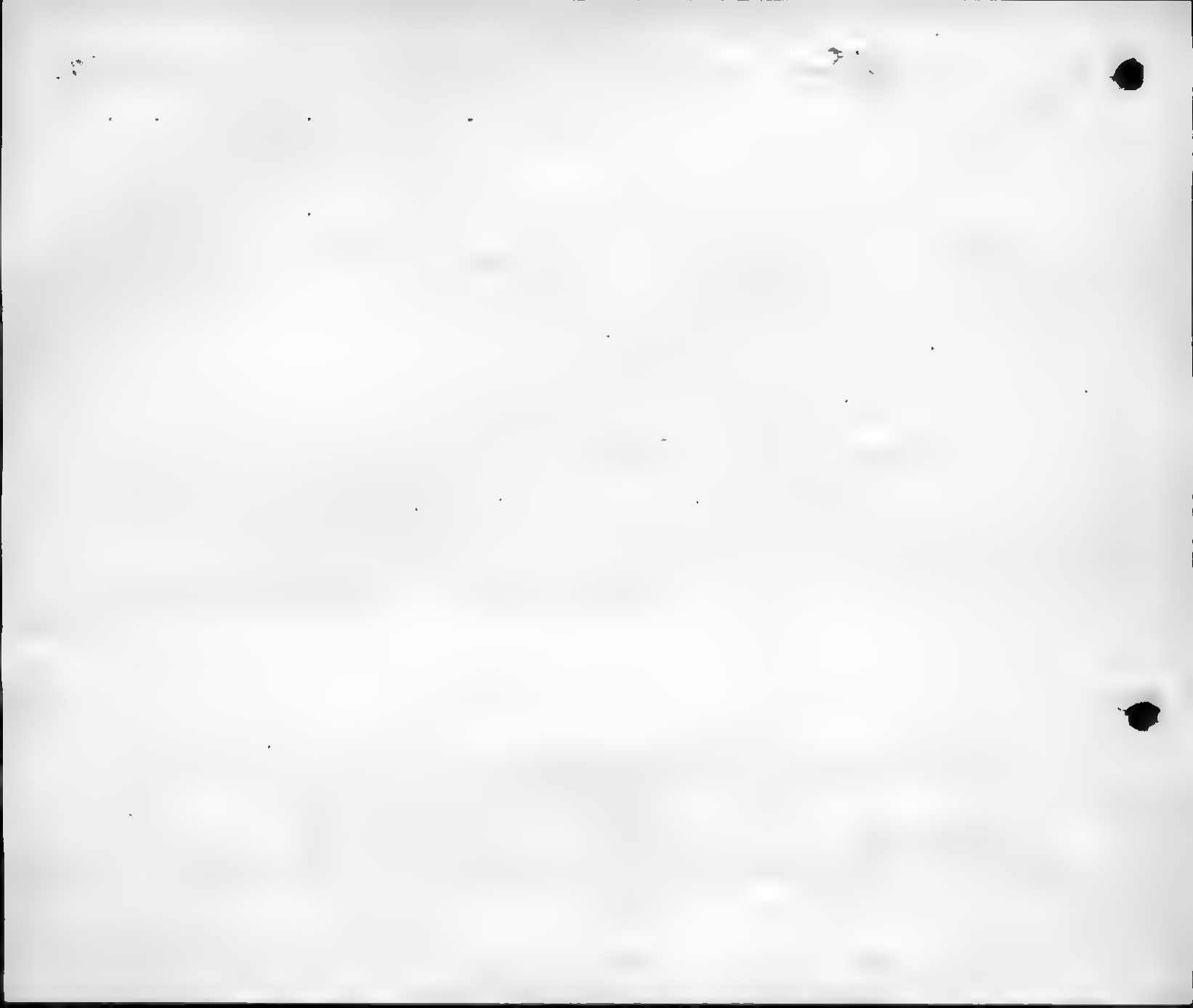


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03931

1 PLACE OF DEATH a. COUNTY <u>Baltimore County</u> Middle River MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>2123 Oakland Rd.</u> b. COUNTY <u>Balto. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>1 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2123 Oakland Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>M.</u> Last <u>Egner</u>		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles W. Pick</u>		14. MOTHER'S MAIDEN NAME <u>Lary Ann Fair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>218-30-2331</u>	
17. INFORMANT <u>Mr Otto Eoner</u>		Address <u>2123 Oakland Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of sigmoid colon</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> , to <u>April 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 25, 1961</u> , and that death occurred at <u>4 A M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis Semenovoff</u>		22b. DATE, SIGNED <u>4/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>		22d. ADDRESS <u>2108 CRENS RD, BALTO 20 MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4-26-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	23d. LOCATION (City, town, or county) (State) <u>Parkville Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassala Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>	
ADDRESS <u>7401 Belair Road</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

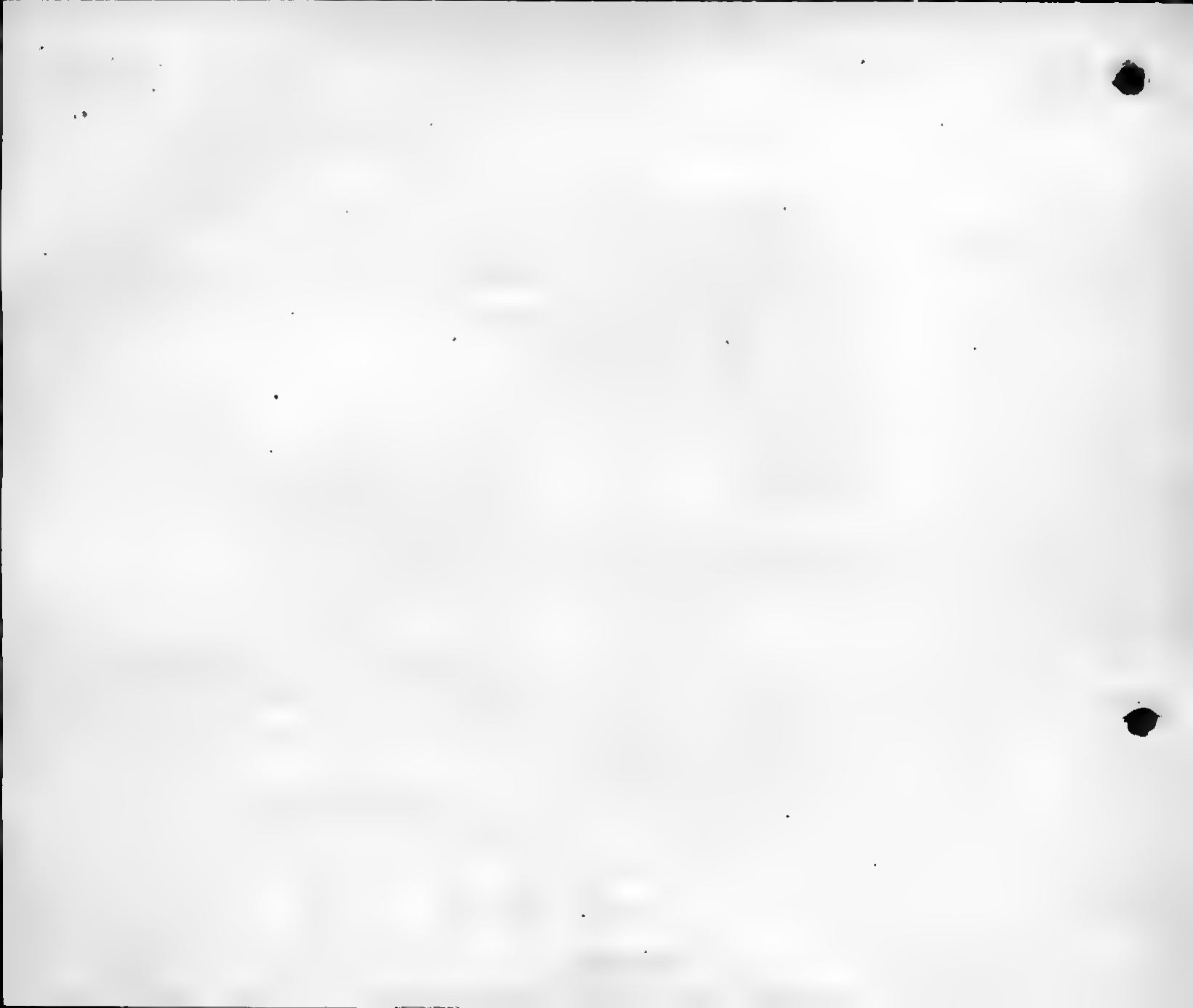


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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3938
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>7-25-60</u> <u>X</u> <u>Ruston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor - Seminary Ave</u>		d. STREET ADDRESS <u>16516 Darnall Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>hou</u> Last <u>Eisele</u>		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-71</u>
9 AGE (In years lost birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Klopfer</u>		14. MOTHER'S MAIDEN NAME <u>Houise Hahn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>C. Plessmann Rn.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Generalized arteriosclerosis and</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>May</u> <u>1960</u> , to <u>412</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>31 30 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Franklin E. Leslie</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie</u>		22d. ADDRESS <u>2929 N. Charles St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial</u>		23b. DATE THEREOF <u>April 5, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Roslyn, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03933

Reg. Dist. No.

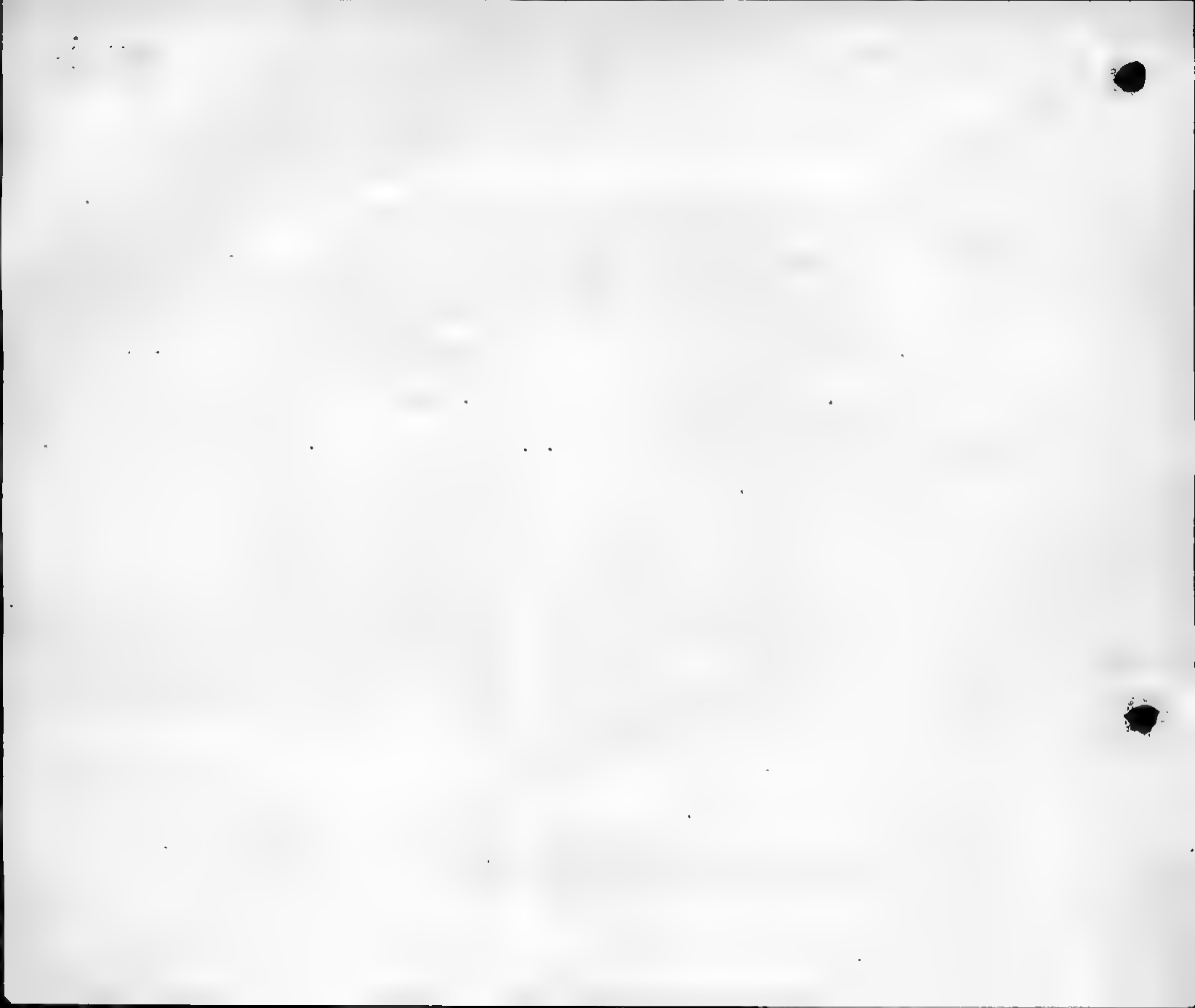
3933

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>G. L. Martin Co.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>2808 Pelham Avenue</u> d. STREET ADDRESS <u>Baltimore</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>ANDREW WILLIAM ENDRES</u> First Middle Last				4. DATE OF DEATH Month Day Year <u>4-20-1961</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/25/1899</u>		9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool Attendant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Martin Co.</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Endres</u>						14. MOTHER'S MAIDEN NAME <u>Barbara Hoffman</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO <u>213-10-1439</u>				17. INFORMANT <u>Theresa Diepold Endres, wife, above</u> Address							
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> (b) <u>A-S-C-V-Disease</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>[Signature]</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>4/21/61</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/24/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> <u>3331 Brehms Lane</u>												24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Schimunek</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Department of Health. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3241
CERTIFICATE OF DEATH

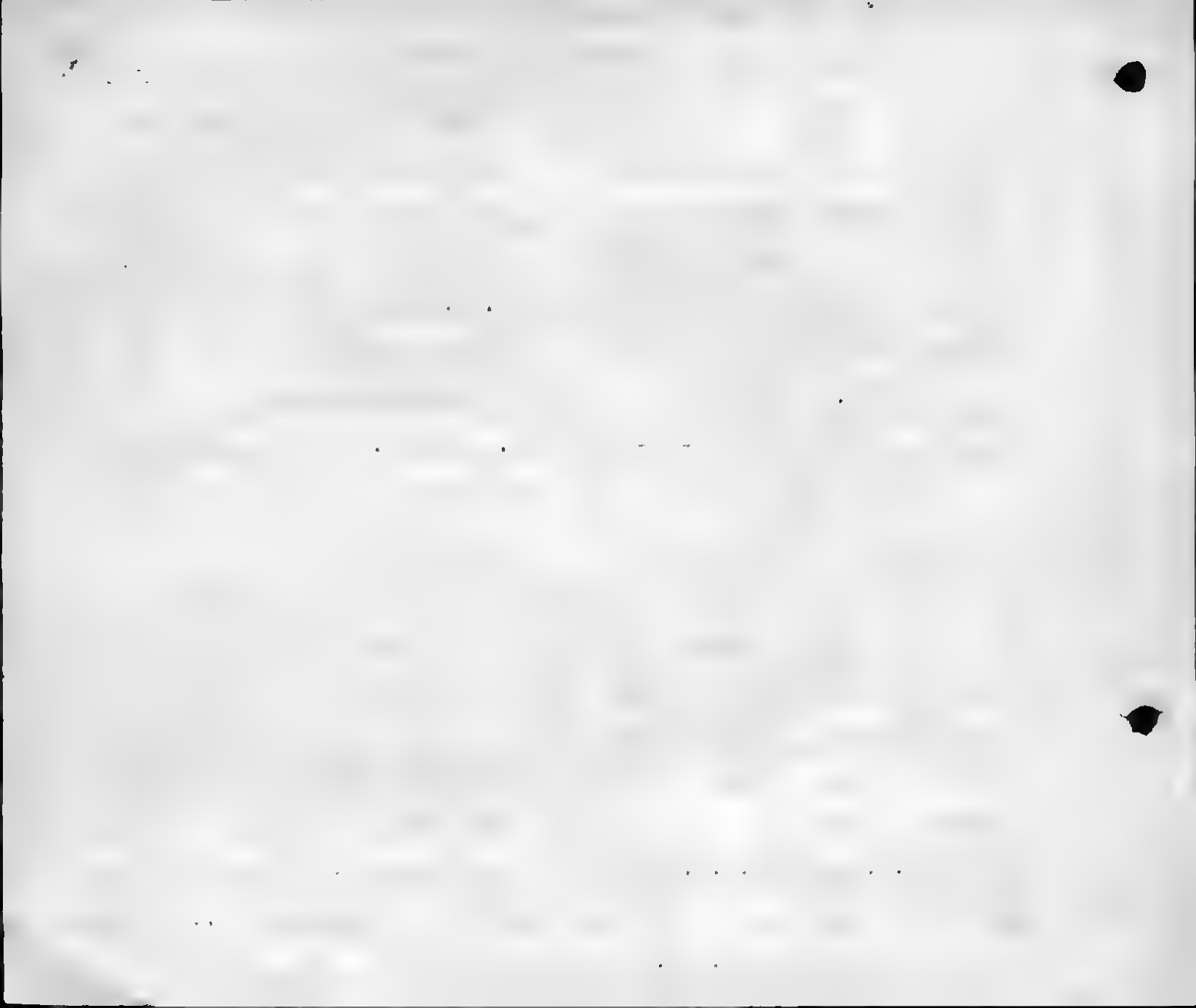
Reg. Dist. No.

03935

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 31 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 40 Portship Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle (NMN) Last EVANS		4. DATE OF DEATH Month April Day 24th Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1899
9. AGE (In years last birthday) yrs 61		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Open Hearth		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David J. Evans		14. MOTHER'S MAIDEN NAME Elizabeth James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-07-4332	
17. INFORMANT Mrs. Laura P. Evans		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNGS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 MONTH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/10 , 19 61 , to 4/24 , 19 61 , that I last saw the deceased alive on 4/19 , 19 61 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3401 Dundalk Avenue 4/25/61			
ACTUAL SIGNATURE W.E. Baermann M.D.		PHYSICIAN'S NAME (Type) W.E. Baermann, M.D. Baltimore 22, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/61	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md		24a. REC'D BY REGISTRAR DATE MAY 1 '61	24b. REGISTRAR'S SIGNATURE Robert S. Thomas

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A11 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3342

03936

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1341 Beechwood Road		d. STREET ADDRESS 1341 Beechwood Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE E. EWING		4. DATE OF DEATH April 22, 19 61	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1912
9 AGE (in years last birthday) 48 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph L. Ewing		14. MOTHER'S MAIDEN NAME Alice Bertram	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elleta Ewing 718 S. 51st St.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary thrombosis DUE TO (c) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 hrs 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1961 to April 22, 1961 , that (I) (we) last saw the deceased alive on April 21, 1961 , and that death occurred at 5 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE John U. Conway		22b. DATE SIGNED 4-25-61	
22c. PHYSICIAN'S NAME (Type) John U. Conway, M.D.		22d. ADDRESS 914 D STREET - BALTO. 19 MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/61	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR APR 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			



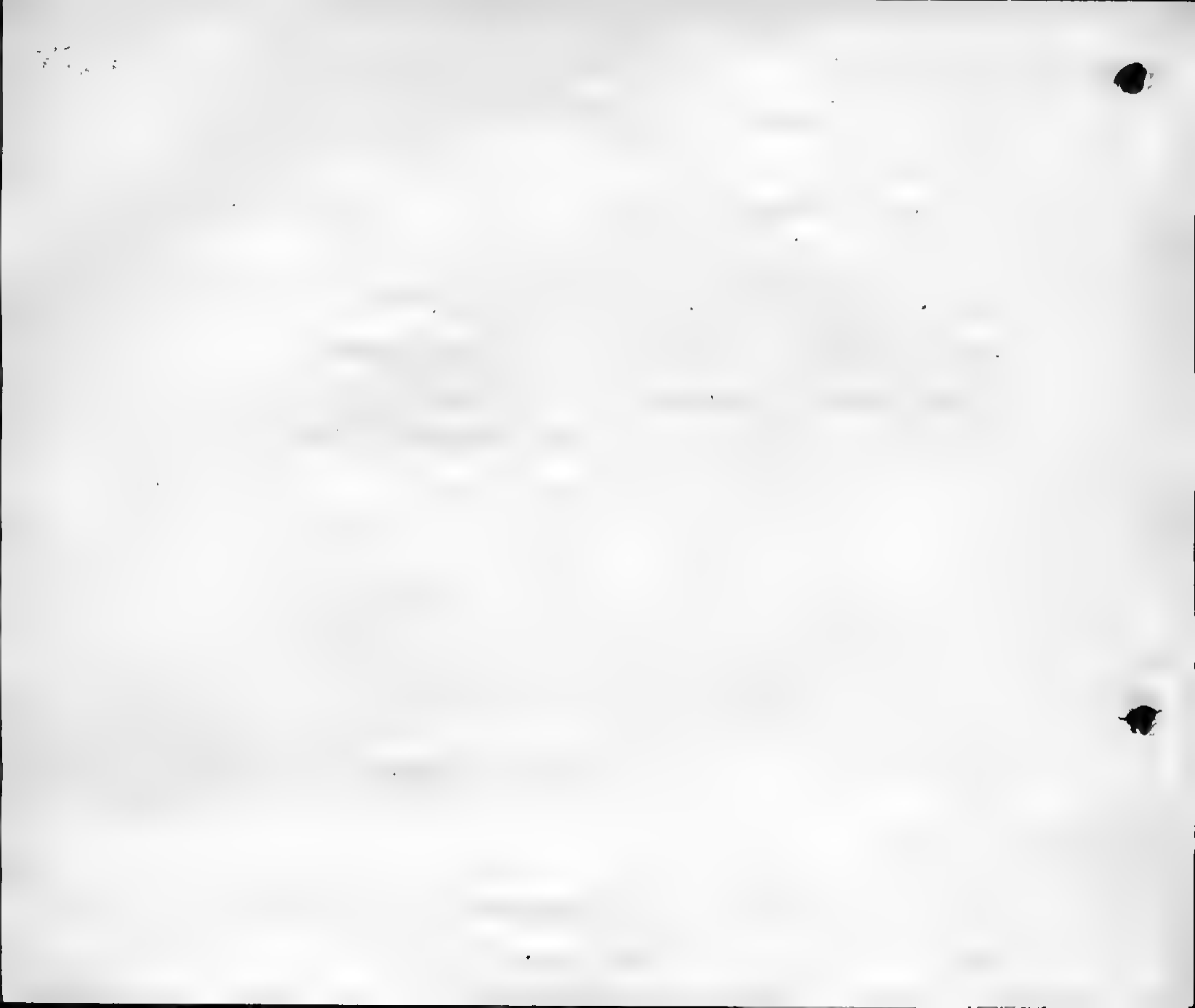
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2043
M
X
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
2043
M
X

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03937

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN 1b <u>years?</u> <u>X Woodlawn, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1428 N. Forest Park Ave.</u>		d. STREET ADDRESS <u>1428 N. Forest Park Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jessie C.</u> Middle <u>Fallice</u> Last <u>Fallice</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1889</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aloysius Welsh</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr Frank J. Fallice</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertensive Cardio-Vas. disease.</u> DUE TO (c) <u>4 years.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/6/12</u> 19 <u>61</u> to <u>Mon-23</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Mon-12</u> 19 <u>61</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles Tommasello</u>		22b. DATE SIGNED <u>4/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Tommasello</u>		22d. ADDRESS <u>910 W. Lombard St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd. Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Courant & Son</u>		25a. REC'D BY REGISTRAR <u>APR 12 '61</u>	
ADDRESS <u>Hollins St.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

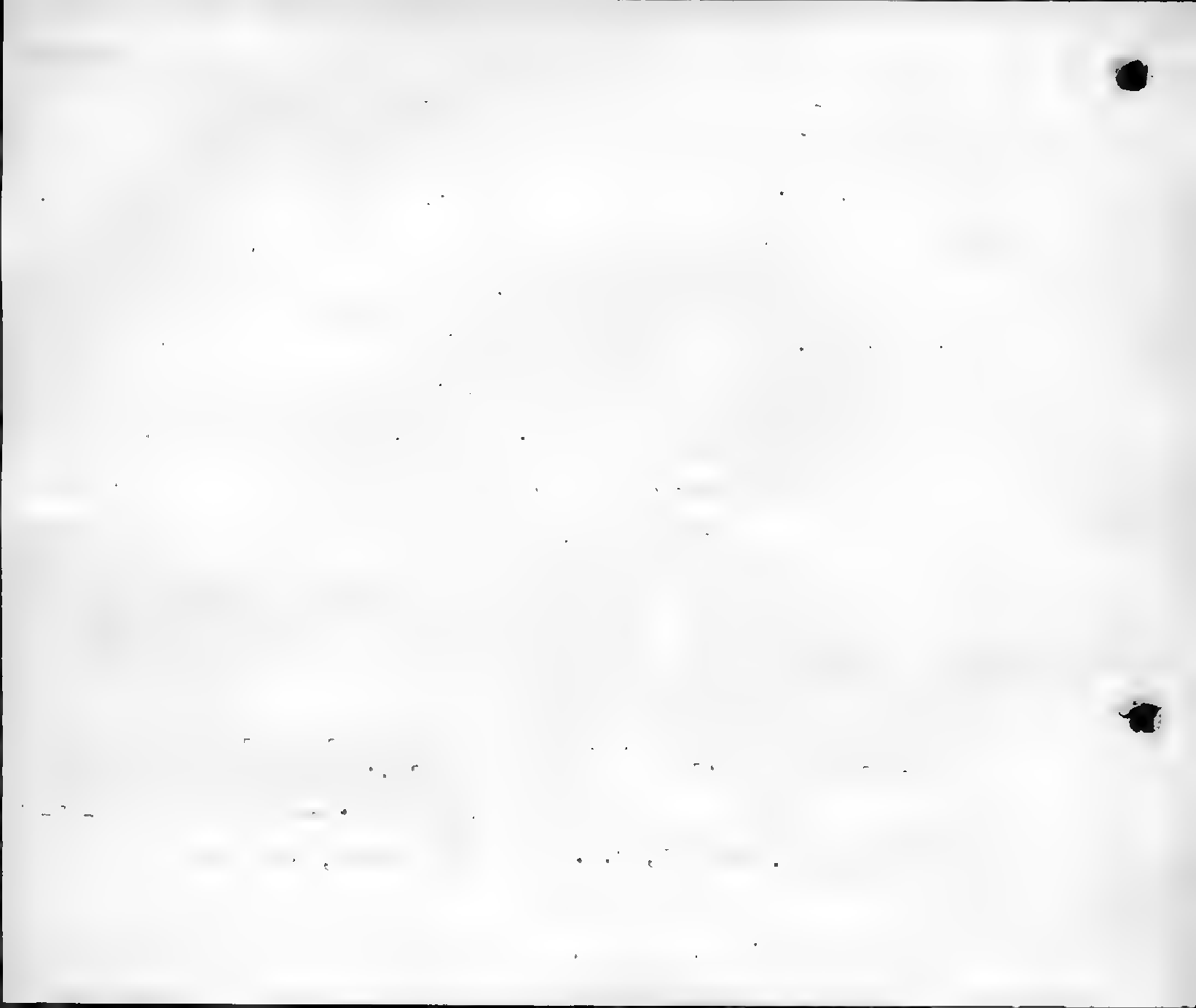
CERTIFICATE OF DEATH

Reg. Dist. No. **03938**

3944

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b Reisterstown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glen Falls Road		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS Glen Falls Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Charles Middle M. Last Fisher		4. DATE OF DEATH Month April Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed by Baltimore County		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest Fisher		14. MOTHER'S MAIDEN NAME Rebecca Whitcomb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Bertha L. Fisher, Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (terminal) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 5, 1960 , to April 16, 1961 , that I last saw the deceased alive on April 15, 1961 , and that death occurred at 12104 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 4-17-61			
ACTUAL SIGNATURE Martin E. Strobel		M.D. 48 Main Street	
PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.		Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 19/61	22c. NAME OF CEMETERY OR CREMATORY Emory Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE APR 18 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Klaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2945

03939

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7800 OAK AVE</u>		d. STREET ADDRESS <u>7800 OAK AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>BLANCHE</u> Last <u>Flickinger</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-1873</u>	
9. AGE (in years last birthday) <u>88</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. UNDER 24 HRS. Hours <u> </u> Min <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>(Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>037010127A</u>	
17. INFORMANT <u>Howard R. Flickinger</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a) <u>Cardio-vascular-renal dis.</u> b) <u>same</u> c) <u>10 yrs.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>none</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (This hospital) attended the deceased from... saw the deceased alive on <u>Apr. 10, 1961</u> , and that death occurred <u>Apr. 14, 1961</u> from the causes end on the date stated above		22a. SIGNATURE <u>A. M. Bacon</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>		22b. DATE SIGNED <u>Apr 14, 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-17-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>APR 17 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. ADDRESS <u>5305 Harford Rd.</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate shall be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

3946
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03940

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>519 Maryland Ave</i>		d. STREET ADDRESS <i>1519 Maryland Ave</i>	
3. NAME OF DECEASED (Type or print) <i>SAMUEL C. FOSTER</i>		4. DATE OF DEATH <i>April 8th 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27-1888</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Standard Oil Co</i>	11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Samuel C. Foster</i>		14. MOTHER'S MAIDEN NAME <i>Mary Chesler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>214-03-6384</i>	17. INFORMANT <i>Anna Foster (wife)</i> Address <i>same as above</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Occlusion</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Jack C. Collins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JACK C. COLLINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 11-1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cem.</i>
22d. LOCATION (City, town, or county) <i>Balto</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John B. Connolly</i>		ADDRESS <i>418 Eastern Blvd 21 Md.</i>	
24a. REC'D BY REGISTRAR <i>APR 11 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kinn</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

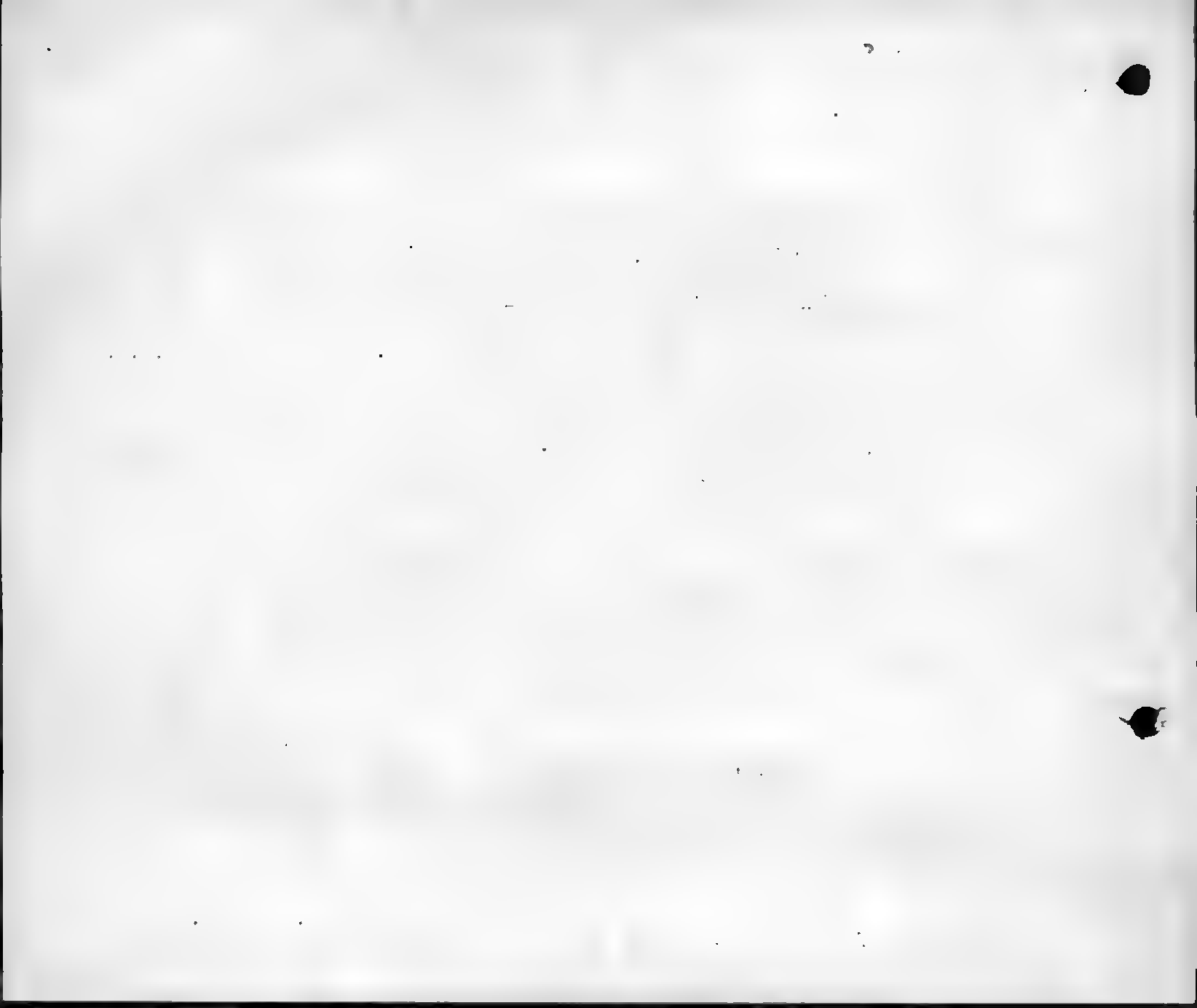
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VR ATs (4)
15M 9/59

3947

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03941

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cowenton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 1069 Red Lion Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>P.</u> Last <u>Francis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1890</u>
9. AGE (in years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Addie Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>J. Proctor Francis</u>		Address <u>Box 1069 Red Lion Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>420.1</u> DUE TO <u>Coronary Thrombosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b). <u>Arteriosclerosis.</u> (c). <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/21, 1959</u> to <u>4/20, 1961</u> , that (I) (we) last saw the deceased alive on <u>4/20, 1961</u> and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Samuel Stern</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type, <u>Samuel STERN.</u>)	
22d. ADDRESS <u> </u>		22e. ADDRESS <u> </u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-26-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Camp Chapel Methodist</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Asa...</u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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3948

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03942

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8732 OLD HARFORD ROAD</u> <u>PARKVILLE.</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8732 OLD HARFORD ROAD. PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8732 OLD HARFORD ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RHODA</u> Middle <u>E</u> Last <u>FRANCIS.</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 22 1876</u>
9. AGE (In years lost birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN L JAMES</u>		14. MOTHER'S MAIDEN NAME <u>CLARA COLE.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CHARLES FRANCIS</u>		Address <u>8732 OLD HARFORD RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Hypertensive chronic arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>depression</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 1/2 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>depression</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March</u> , 19 <u>61</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>William Harris,</u> M.D.		22b. DATE SIGNED <u>APR 10 '61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APRIL 10, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CAMP CHAPEL</u>	23d. LOCATION (City, town, or county) (State) <u>PERRY HALL MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Funeral Home</u>		25. REGISTRATION BY REGISTRAR DATE <u>APR 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

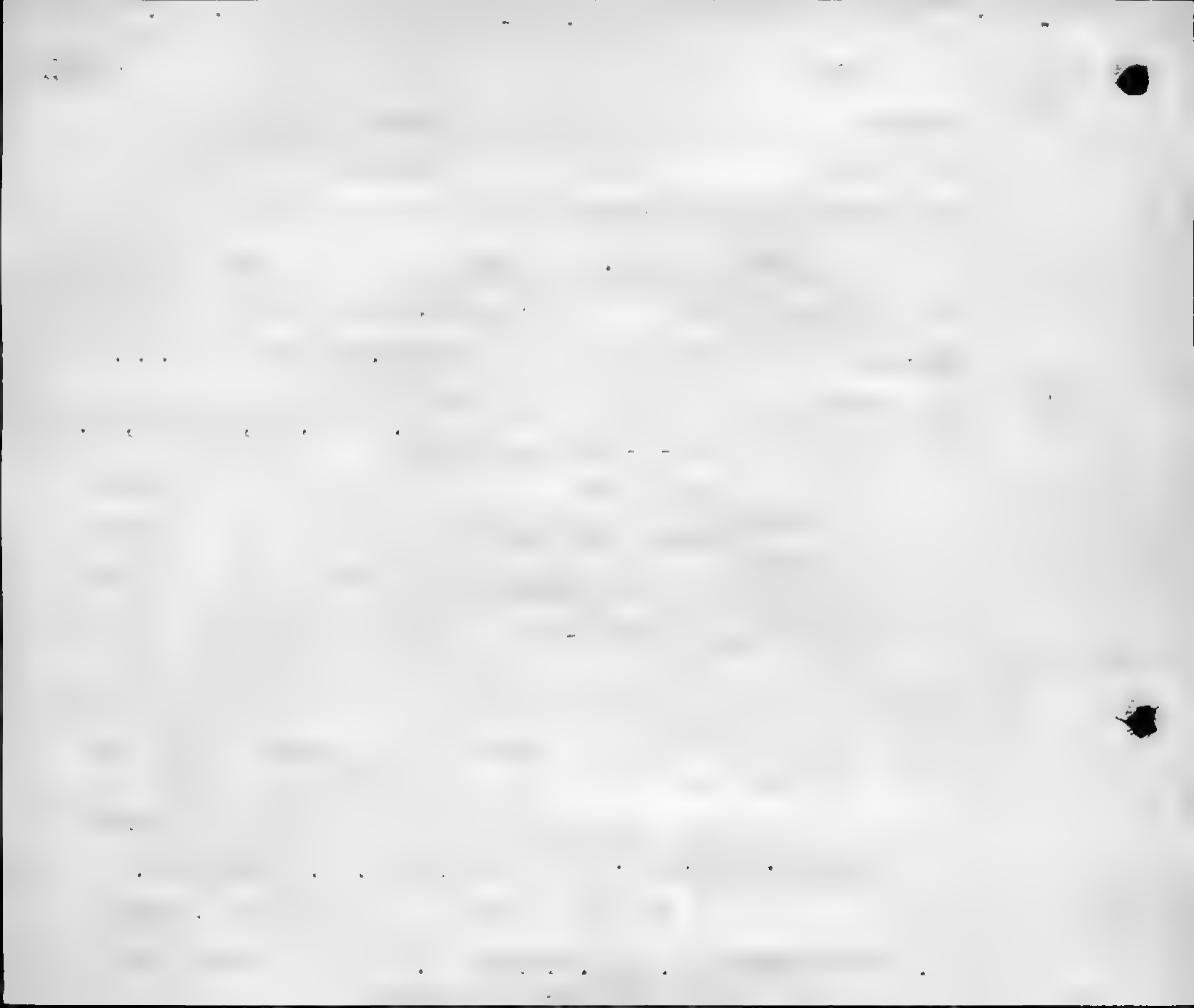


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
3049													
03943													
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 89 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2810 Riggs Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) THOMAS D. FREEMAN						4. DATE OF DEATH Month April Day 23 Year 1961							
5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH December 18, 1918 9. AGE (In years last birthday) 42 yrs. IF UNDER 1 YEAR Months Days Hours Min						10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef - Cook 10b. KIND OF BUSINESS OR INDUSTRY Restaurant 11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Douglas Freeman						14. MOTHER'S MAIDEN NAME Bessie Thomas							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II						16. SOCIAL SECURITY NO. 218-22-4669 17. INFORMANT Clin. Records, VAM, Balto 18, Md. Fort Howard Division							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE PULMONARY EDEMA (b) CONGESTIVE HEART FAILURE (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). DIABETES MELLITUS WITH KIMMELSTEIL-WILSON DISEASE AND NEUROPATHIES												INTERVAL BETWEEN ONSET AND DEATH HOURS UNKNOWN YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that he (this hospital) attended the deceased from January 24, 1961 to April 23, 1961 , that he (we) last saw the deceased alive on April 23, 1961 , and that death occurred 12:30 PM from the causes and on the date stated above.												22b. DATE SIGNED 4/23/61	
22a. SIGNATURE Joseph J. Cillo, M.D.						22c. PHYSICIAN'S NAME (Type) JOSEPH J. CILLO, M. D.							
22d. ADDRESS VAH, BALTO, MD. FT HOWARD DIV.						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4-27-61						23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL 23d. LOCATION (City, town or county) (State) BALTIMORE 28, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. JOHNSON FUNERAL HOME, 1011 N. Arlington St., Baltimore, Maryland						25a. REC'D BY REGISTRAR APR 25 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Finck							



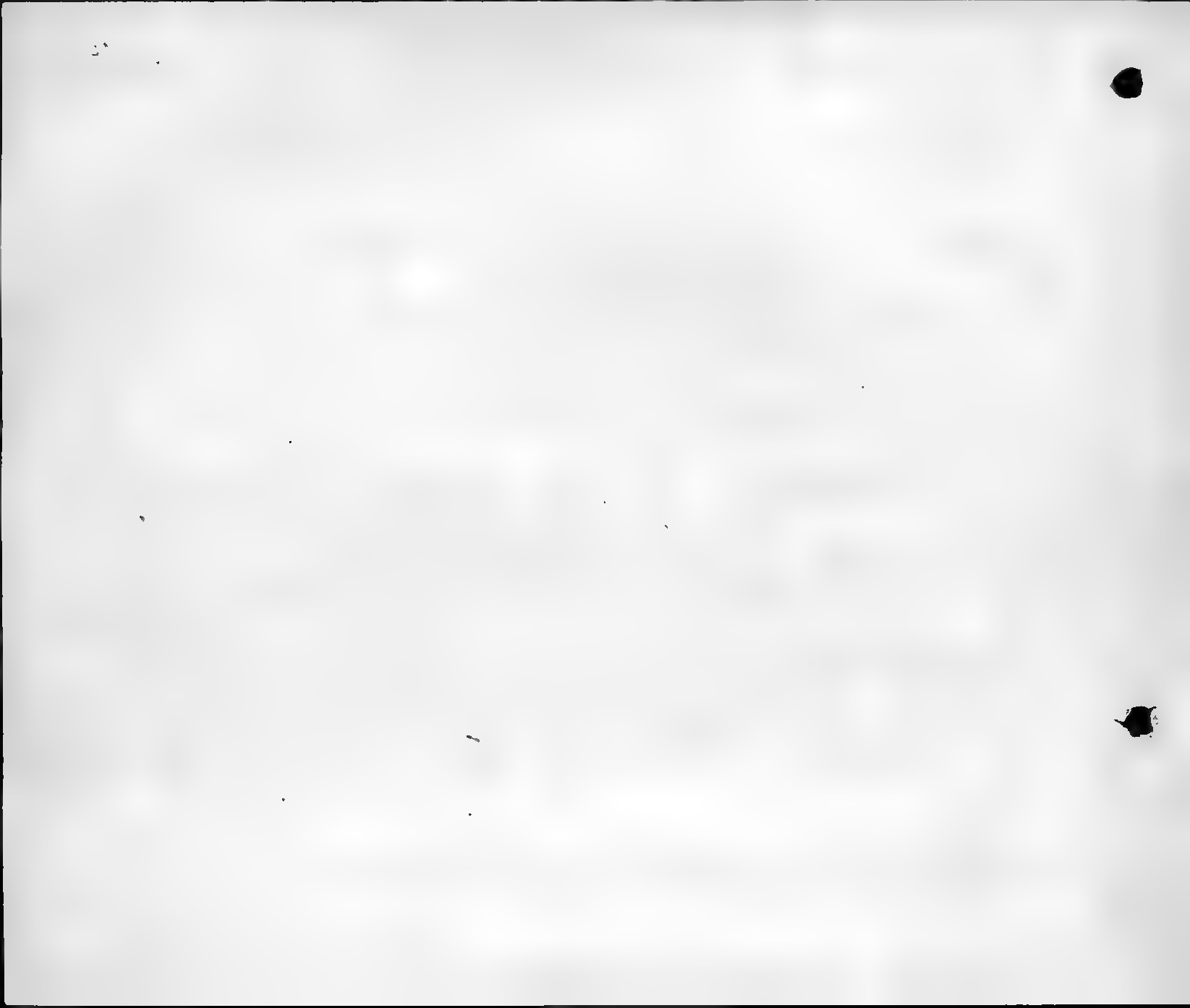
CERTIFICATE OF DEATH

Reg. Dist. No. 03944

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>308 Murdock Rd. #12</u>		d. STREET ADDRESS <u>308 Murdock Rd. #12</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Frisch</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1879</u>
9. AGE (In years last birthday) yrs <u>81</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Merchant</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Frisch</u>		14. MOTHER'S MAIDEN NAME <u>Marie Sohne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-2332</u>	
17. INFORMANT <u>George C. Frisch</u>		Address <u>308 Murdock Rd. #12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 20, 1955</u> to <u>April 11, 1961</u> , that I last saw the deceased alive on <u>April 11, 1961</u> and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6805 York Rd Baltimore 12 MD 4-12-61</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/15/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Gar.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Townson Inc.</u>		ADDRESS <u>1050 York Rd. #4</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



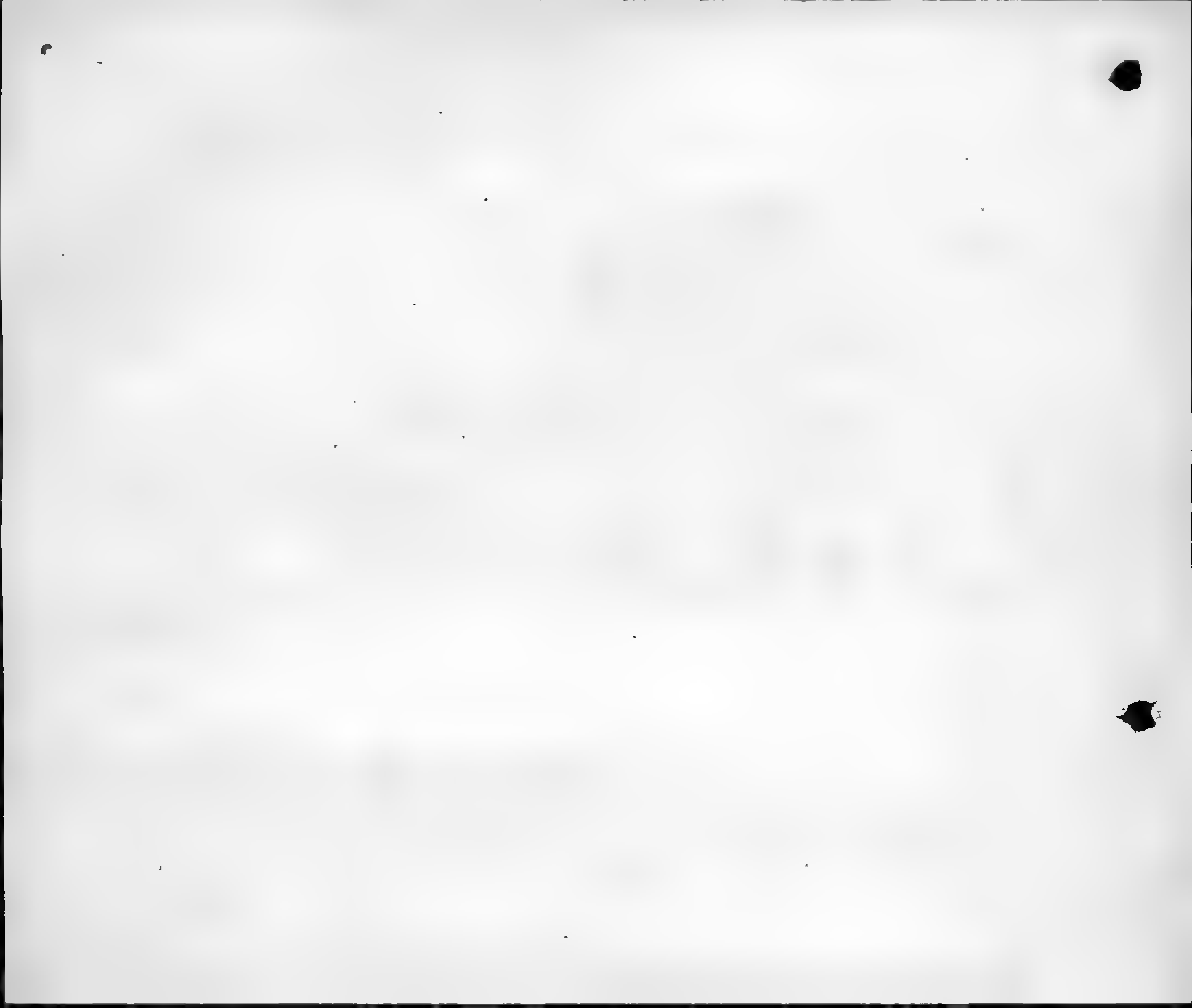
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
2051
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03945

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 57 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Ba7to. ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1508 Eastern Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Fuhrman				4. DATE OF DEATH Month 4 Day 1 Year 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/12/1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76		IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar-tender				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George P. Fuhrman				14. MOTHER'S MAIDEN NAME Emma S. Houck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 214-14-0840		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far Advanced Pulmonary Tuberculosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 mo							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Advanced Pulmonary Tuberculosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/3 19 61 to 4/1 19 61 , that (I) (we) last saw the deceased alive on 4/1 19 61 , and that death occurred on 4/1 19 61 , from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent	
22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-61		23c. NAME OF CEMETERY OR CREMATORY Hampstead		23d. LOCATION (City, town, or county) General Co Md (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Yipton				25a. REC'D BY REGISTRAR APR 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

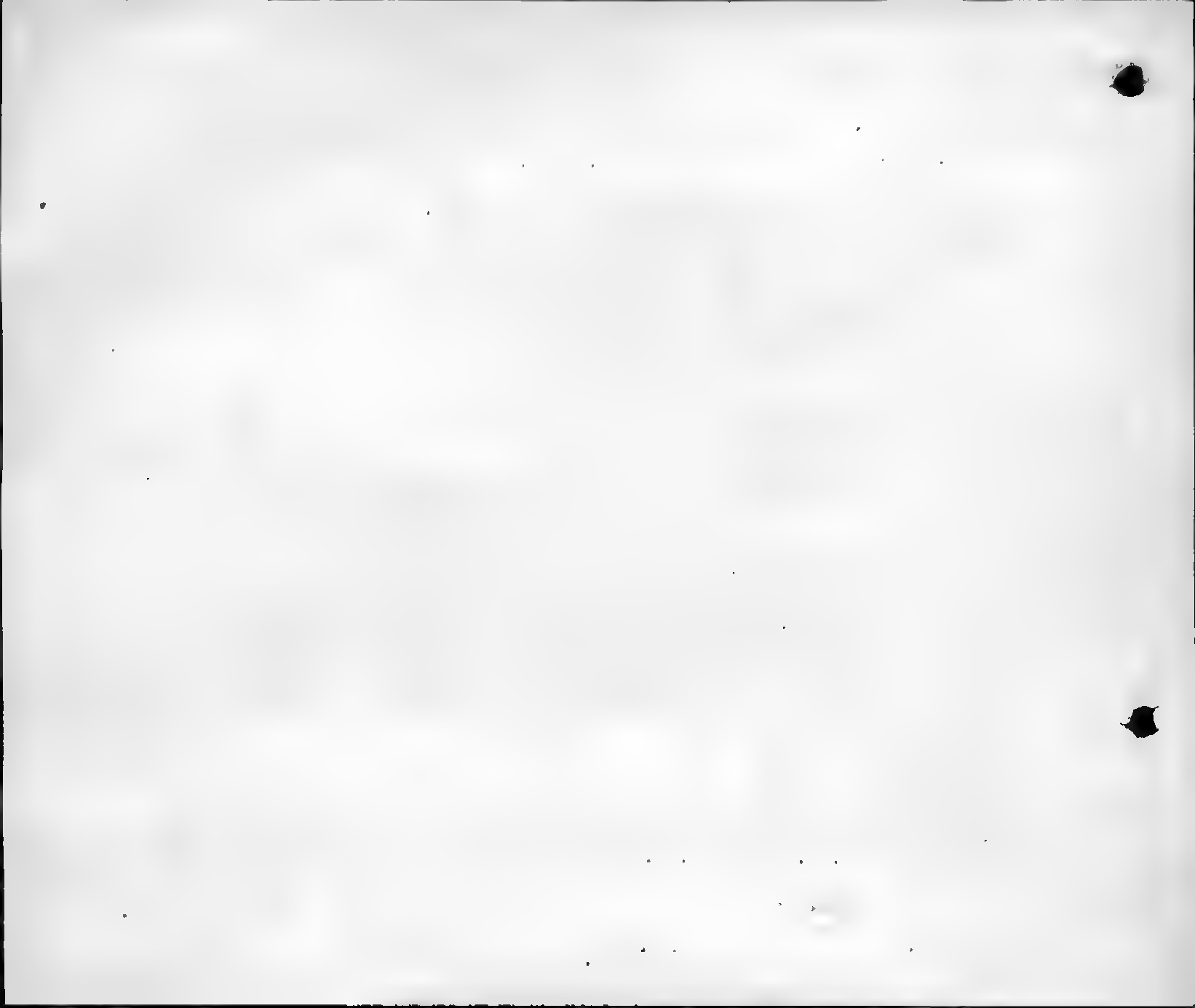
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3952

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03946

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 3Yrs. 6Mos. 23Das.		d. STREET ADDRESS 4606 N. Charles Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Garrett Last Garrett		4. DATE OF DEATH Month April Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investment Banker		10b. KIND OF BUSINESS OR INDUSTRY Brokerage	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Garrett		14. MOTHER'S MAIDEN NAME Alice Whiteridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1917 - 1918	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Chronic myocarditis (b) Gen. arteriosclerosis DUE TO Chr. Brain Syndrome due to Sickle Brain Dis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Brain Syndrome due to Sickle Brain Dis		INTERVAL BETWEEN ONSET AND DEATH 7 mos. 5 yr + 11	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 2, 1957 to April 25, 1961 that (I) (we) last saw the deceased alive on April 24, 1961 and that death occurred on April 25, 1961 from the causes and on the date stated above.			
22a. SIGNATURE W. W. Elgin		22b. DATE SIGNED April 25, 1961	
22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		22d. ADDRESS Towson 4, Maryland The Sheppard and Enoch Pratt Hospital,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/28/61	
23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc.		25a. REC'D BY REGISTRAR DATE APR 26 '61	
25b. REGISTRAR'S SIGNATURE William P. Hester			

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

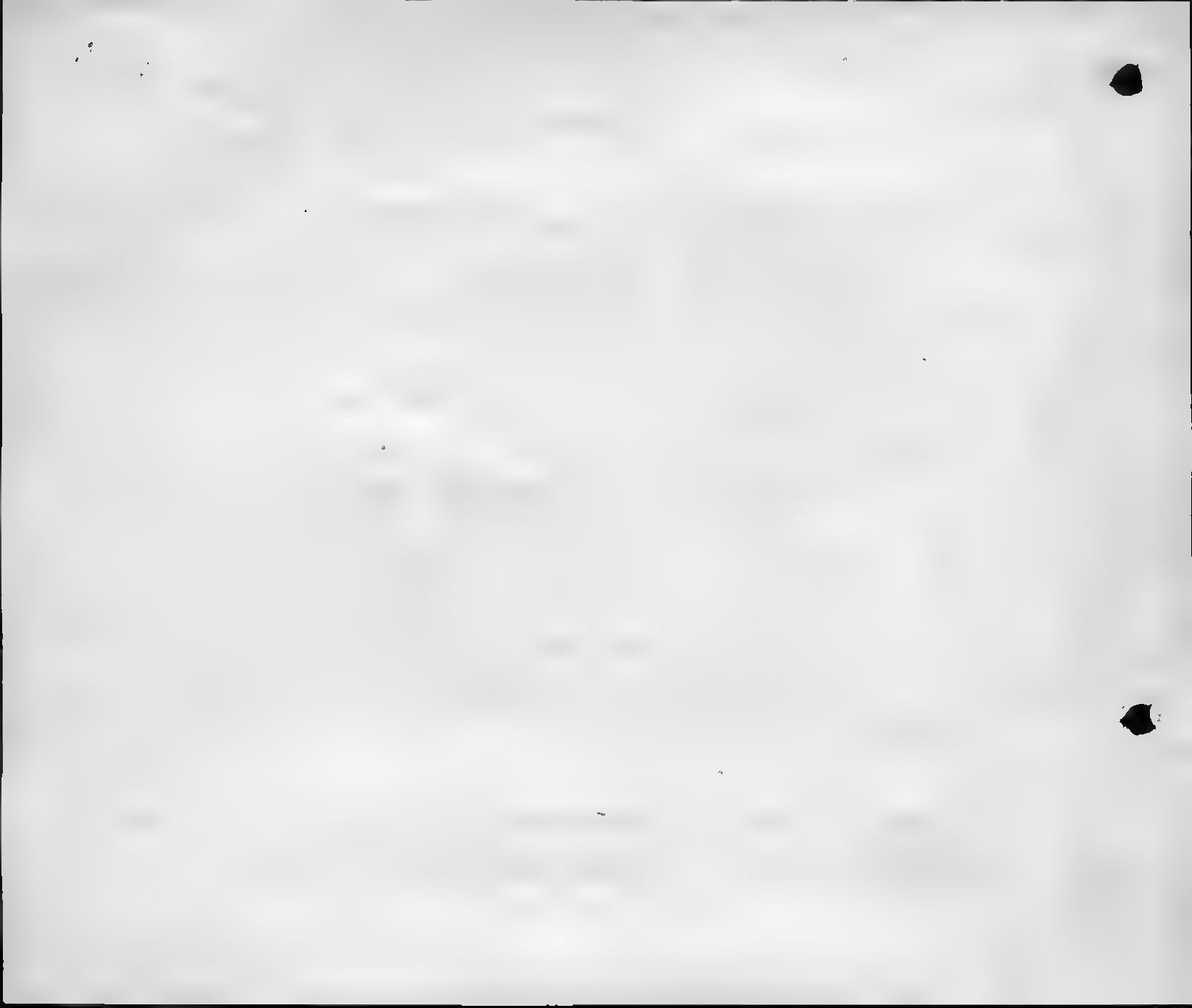
3953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03947

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM c. LENGTH OF STAY IN b. 104 LONGRIDGE COURT d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 104 LONGRIDGE COURT		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM d. STREET ADDRESS 104 LONGRIDGE COURT	
3. NAME OF DECEASED (Type or print) IDA VIRGINIA GATES		4. DATE OF DEATH APRIL 14 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7, 1873
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Mins.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		12. KIND OF BUSINESS OR INDUSTRY MARYLAND	
13. FATHER'S NAME HENRY SHOUL		14. MOTHER'S MAIDEN NAME ANNA L. DAVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO EDNAG. BRADENBAUGH - 104 LONGRIDGE CT	
17. INFORMANT NO EDNAG. BRADENBAUGH - 104 LONGRIDGE CT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 720.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH Sudden	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. C'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. C'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/17/61	
22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		22d. LOCATION (City, town, or country) (State) BALTIMORE - MD.	
23. FUNERAL DIRECTOR W. M. COOK-TOWSON, INC. TOWSON, MD		24a. REC'D BY REGISTRAR APR 18 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

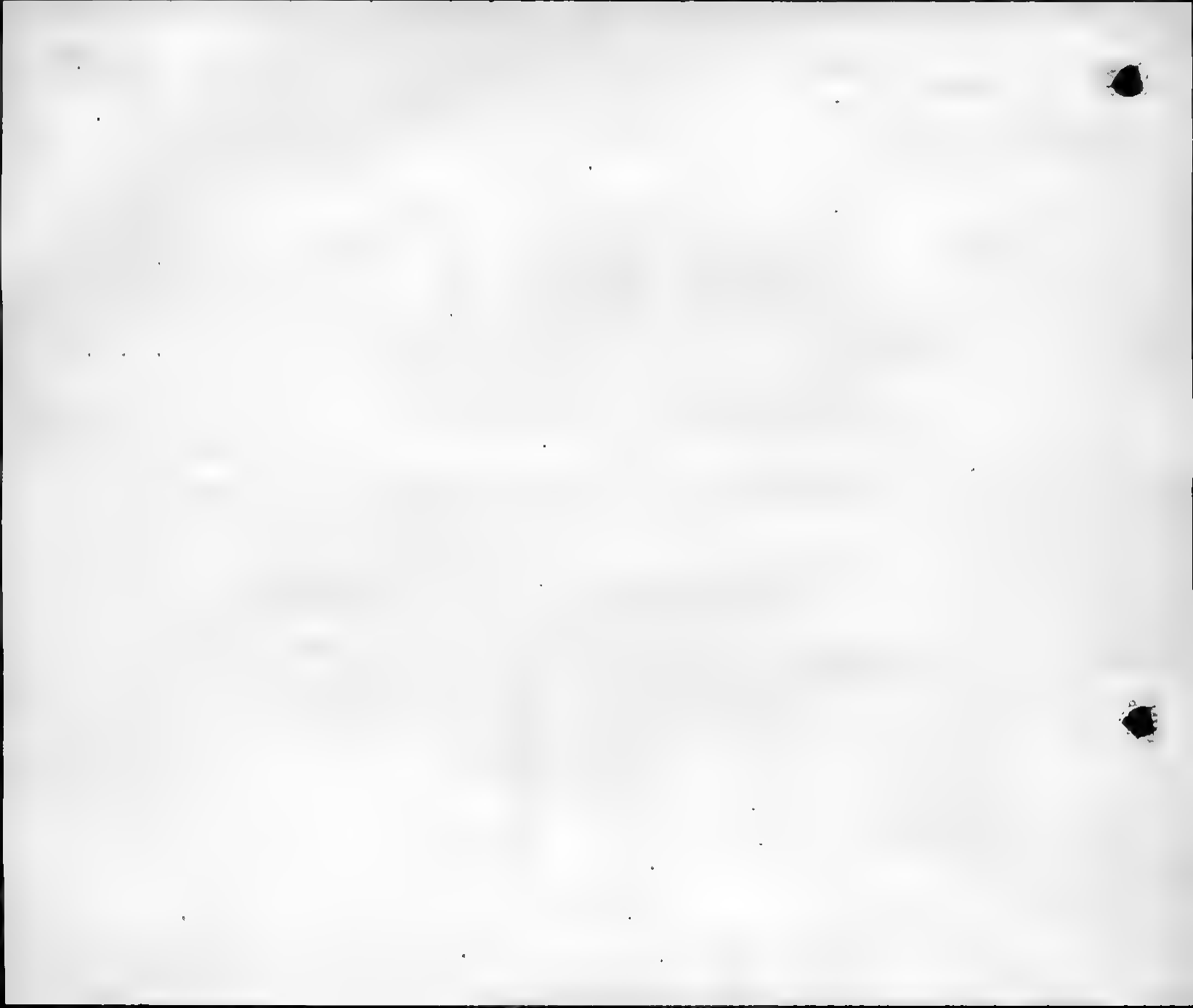


1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2954

03948

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Pennsylvania b. COUNTY Luzerne Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 mo's.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hazleton
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph's Nursing Home		d. STREET ADDRESS 110 W. ELM ST.	
3. NAME OF DECEASED (Type or print) First Middle Last Louis T. Gentilini		4. DATE OF DEATH Month Day Year Apr. 13, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 24, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Austria
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Dr. Joseph Velky 2010 Fernglen Way Catonsville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and Congestive Heart Failure 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hemiparesis 2 wks ago. Immobility DUE TO (c) Parkinsonism, Severe: Generalized Arteriosclerosis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 wks 4 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to April 13, 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 11 M, from the causes and on the date stated above			
22a. SIGNATURE Emidio Bianco M.D.		22b. DATE SIGNED 4/14/61	
22c. PHYSICIAN'S NAME (Type) Emidio Bianco M. D.		22d. ADDRESS 6322 Windsor Mill Rd Bkto #7	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal for burial		23b. DATE THEREOF 4/17/1961	
23c. NAME OF CEMETERY OR CREMATORY Our Lady of Mt. Carmel		23d. LOCATION (City, town, or county) (State) Hazleton, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Eastern Funeral Home		25a. REC'D BY REGISTRAR APR 19 1961	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

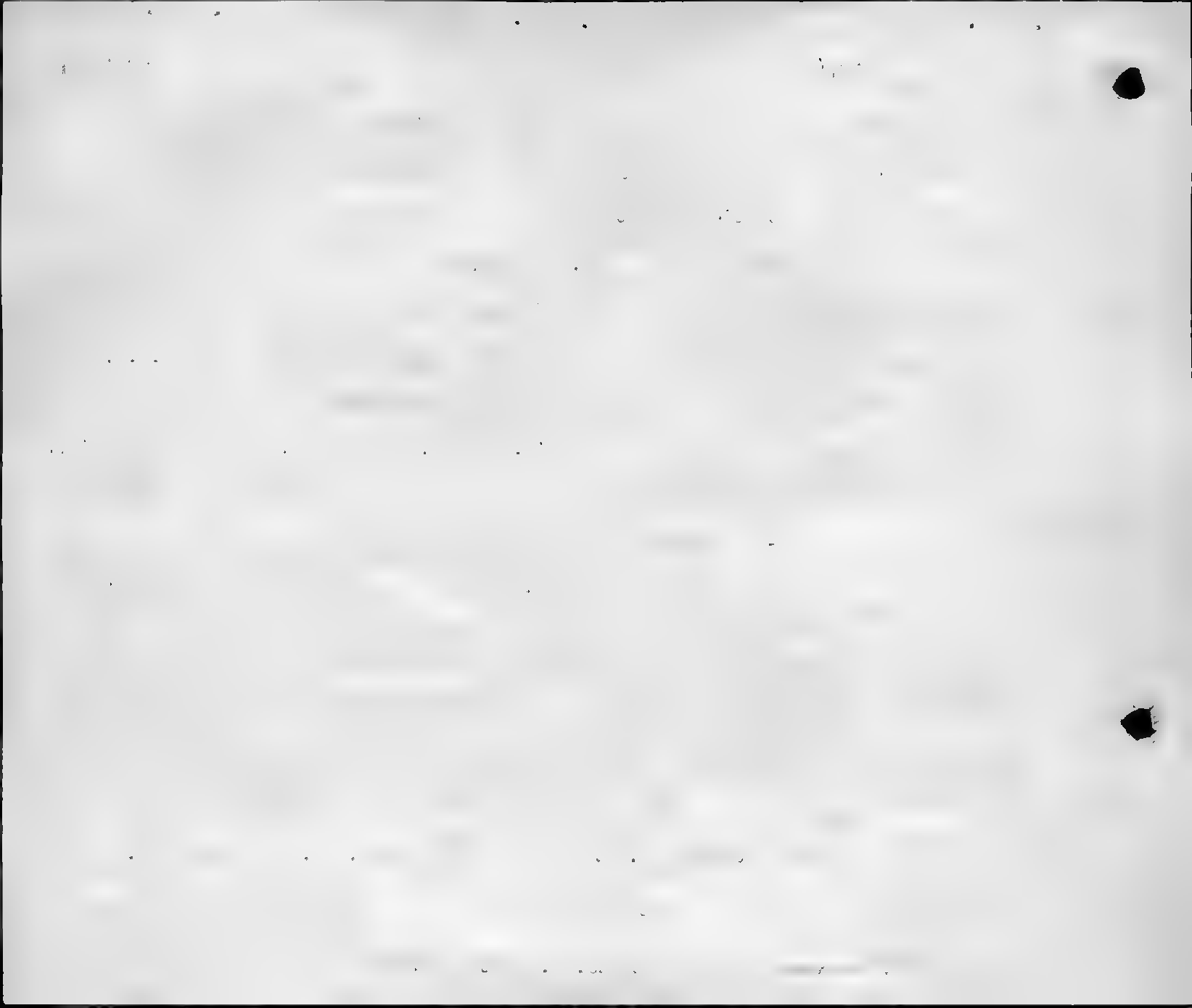
3955

It m 220, 1111 G285 4/24/61 iwk

03949

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN It 21 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 100 N. Potomac Street					
3. NAME OF DECEASED (Type or print) JAMES F. GODZIK		4. DATE OF DEATH Month April Day 10 Year 1961					
5. SEX Male		6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH February 27, 1897					
9. AGE (In years last birthday) 64 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months	Days						
11. BIRTHPLACE County & State, or foreign country Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Henry Godzik		14. MOTHER'S MAIDEN NAME Bertha Rachuba					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-03-4859					
17. INFORMANT Clin. Records. VAH, Balto. Md. Ft. Howard Div.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) BRONCHOPNEUMONIA					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO HEPATOMA 2 DUE TO CHRONIC CHOLECYSTITIS WITH CHOLELITHIASIS 3 DUE TO ARTERIOSCLEROSIS, MARKED 4		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from March 20, 1961 to April 10, 1961 , that (X) (we) last saw the deceased alive on April 10, 1961 , and that death occurred at 1:52 PM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Crahan M.D.		22b. DATE SIGNED 4/11/61					
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIV.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/61					
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Bernard A. Debrowski		25a. REC'D BY REGISTRAR APR 18 '61					
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

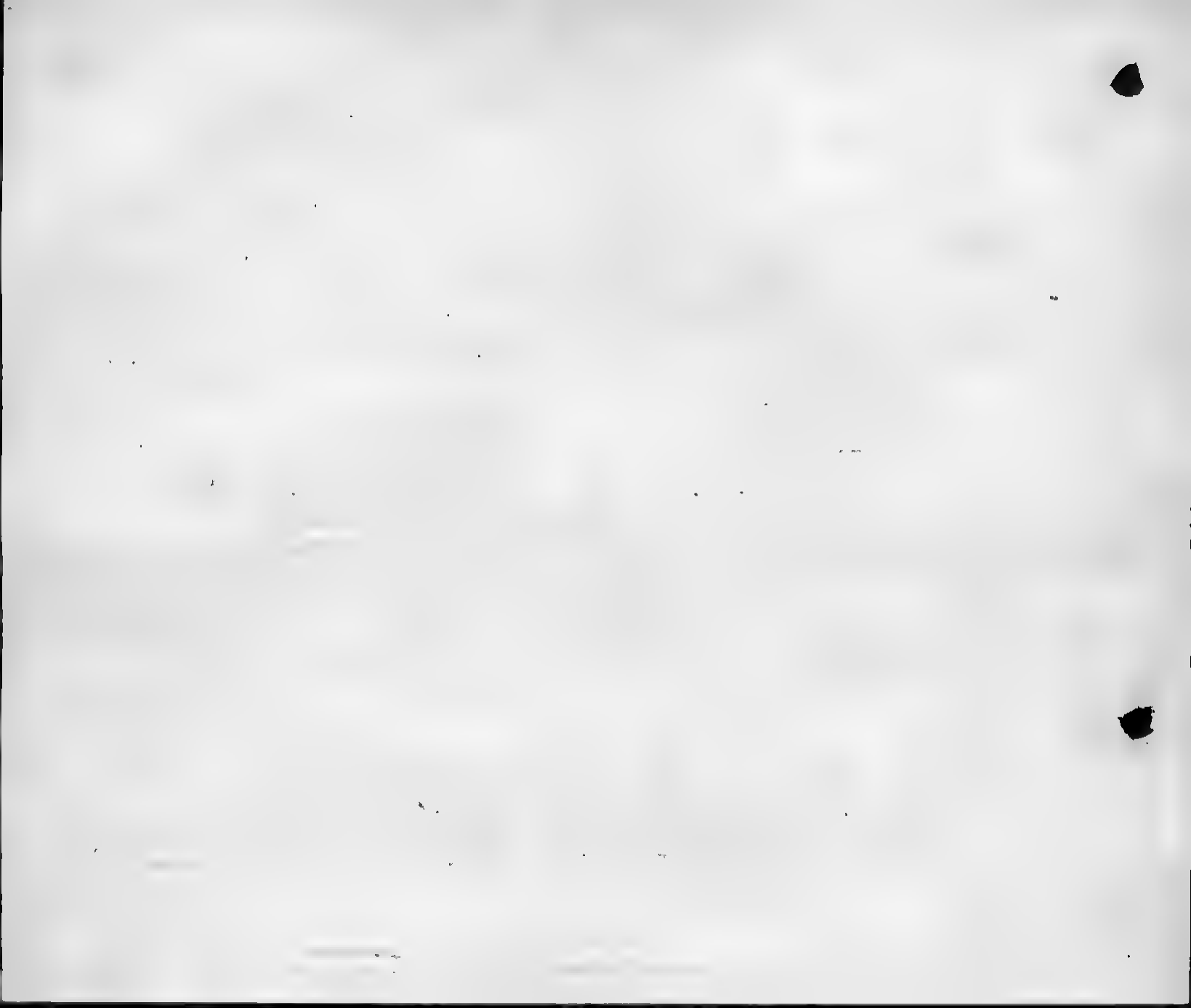
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2956

CERTIFICATE OF DEATH

03950

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City d. STREET ADDRESS Box 76 Biddle Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Henry Grabowski		4. DATE OF DEATH Month April Day 14 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1933
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 28 yrs.
11. BIRTHPLACE (County & State, or foreign country) Cecil County Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Grabowski		14. MOTHER'S MAIDEN NAME Bertha Javoroski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rosewood Records; Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic bilat. bronchopneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19....., to 19....., that (I) (we) last saw the deceased alive on 19....., and that death occurred at 5 A.M., from the causes and on the date stated above.			
22a. SIGNATURE Peter W. Rieckert		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Peter W. Rieckert		22d. ADDRESS 4307 Mainfield Ave, Balt 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/1961	
23c. NAME OF CEMETERY OR CREMATORY St. Rose		23d. LOCATION (City, town or county) (State) Chesapeake Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		25a. REC'D BY REGISTRAR APR 20 '61	
ADDRESS W. G. Zinsky		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



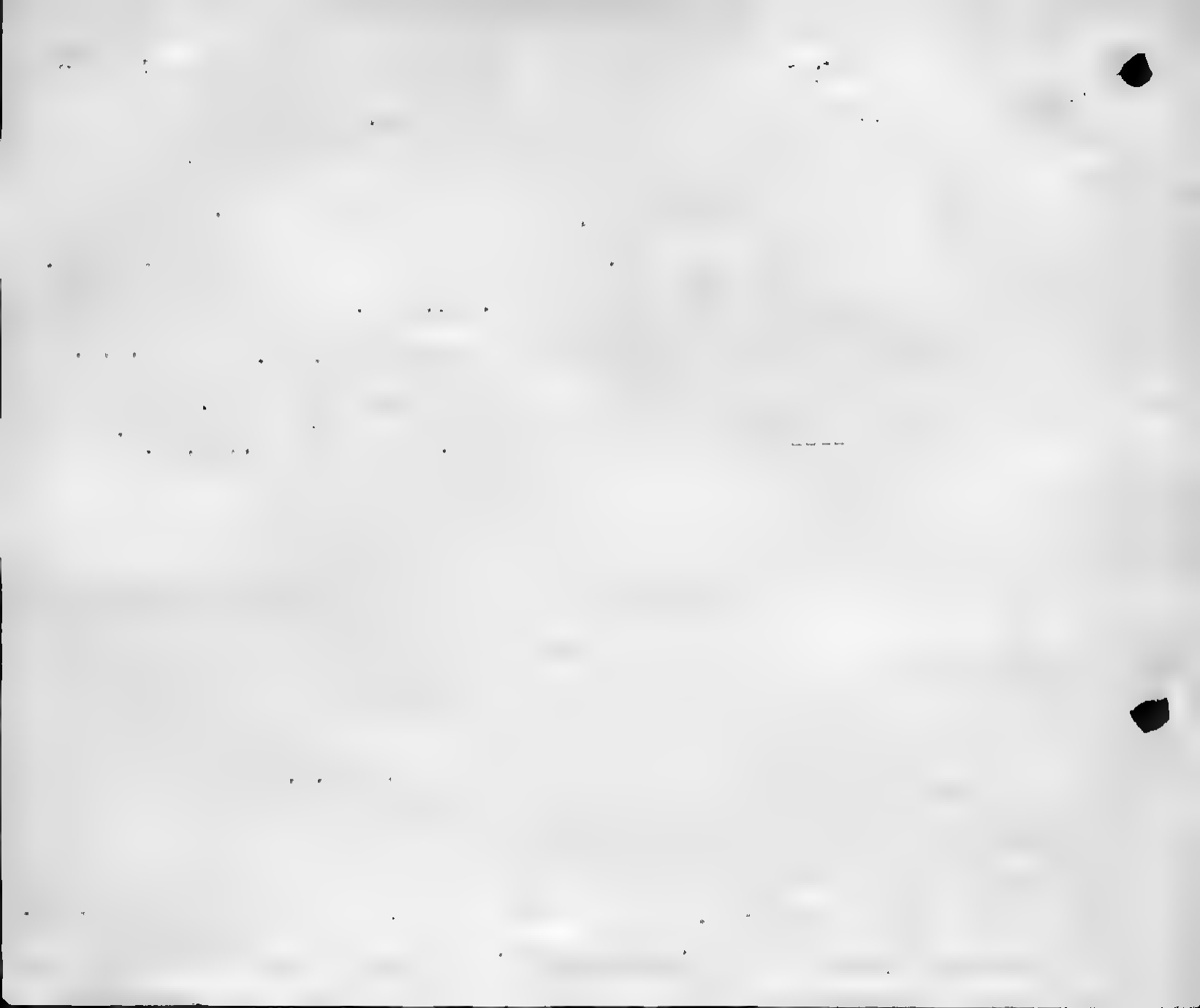
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03951

2057

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paradise Nursing Home Paradise and Altamont Aves.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY 2001 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore # 24, d. STREET ADDRESS 3243 Fait Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE M. GRAY		4. DATE OF DEATH Month April Day 6 Year 1961	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1893.
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Zapf		14. MOTHER'S MAIDEN NAME Margaret Lang	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edward G. Gray		18. ADDRESS 6818 Conley St. Balto., 24, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: I. IMMEDIATE CAUSE (a) Heart Coronary Occlusion (b) Hypertensive Cardiac Vascular Disease (c) Senescent Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Deep vein Thrombosis - Right Foot			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 19 55 to April 6, 1961 that (I) (we) last saw the deceased alive on 4/6 1961 and that death occurred at 9:45 from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Gailer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) M. S. JAWORSKI, M.D.		22d. ADDRESS 2711 Eastern Ave Balto 24	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-61	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City, town or county) (State) 7401 German Hill Rd., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Gailer		25a. REC'D BY REGISTRAR APR 11 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Gailer		25c. ADDRESS 901 S. Conkling St. BALTO., 24, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

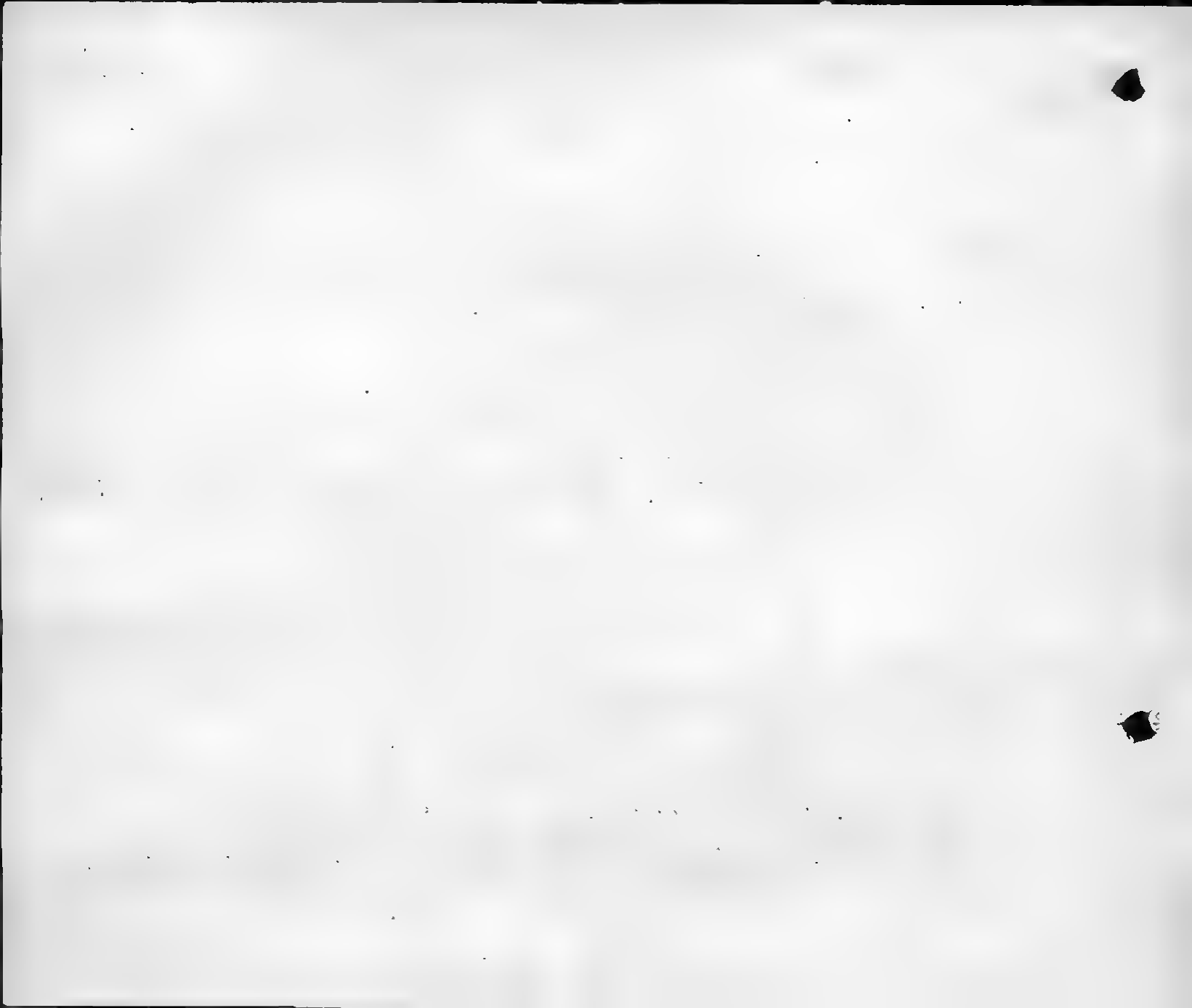
CERTIFICATE OF DEATH

2058

Item 9-1111-1200 2/5/01 iwk

03952

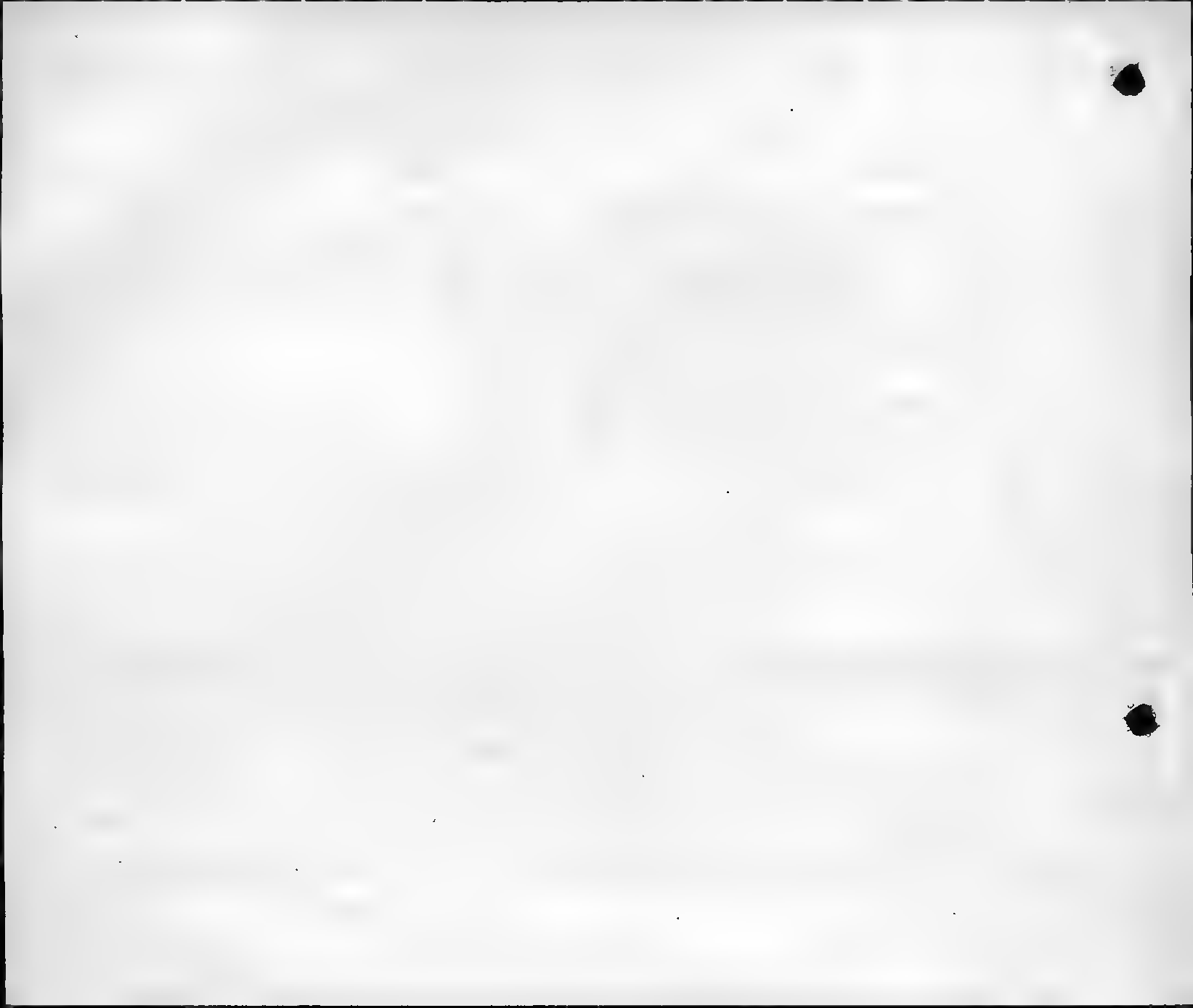
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE California b. COUNTY Los Angeles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm		c. LENGTH OF STAY IN 1b Visiting	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glen Arm Road		d. STREET ADDRESS 1 Glen Arm Road 437	
3. NAME OF DECEASED (Type or print) John E. Gray		4. DATE OF DEATH April 23 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1 - 1931
9. AGE (In years lost birthday) 22 7/8 yrs		10. IF UNDER 1 YEAR: Months 13 Days 10 Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Appliance Repair		10b. KIND OF BUSINESS OR INDUSTRY General Electric	
11. BIRTHPLACE (State or foreign country) Jefferson Co. ansas		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Randolph Gray		14. MOTHER'S MAIDEN NAME Lary L. Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 374 05 8478	
17. INFORMANT Mrs Violet Wood		Address Glenarm Road Glen Arm Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 13 HRS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 23 1961 to April 23 1961 , that (I) (we) last saw the deceased alive on April 23 1961 , and that death occurred at 4:23 PM , from the causes and on the date stated above.			
22a. SIGNATURE CLIFFORD F HUDSON		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CLIFFORD F HUDSON		22d. ADDRESS FCRCK, M.D.	
23a. BURIAL CREMATION CREMATION		23b. DATE THEREOF 4-25-1961	
23c. NAME OF CEMETERY OR CREMATORY Charity Christian Ch Cem.		23d. LOCATION (City, town, or county) (State) Springfield Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE Miss Helen Funder Home 7401 Belair Road		25a. REC'D BY REGISTRAR APR 26 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles S. Hume	



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TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3953
CERTIFICATE OF DEATH
03953

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essa-f</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Essa-f</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>453 Turner Rd. Balto. 21</i>		d. STREET ADDRESS <i>1 453 Turner Rd. (21)</i>	
3. NAME OF DECEASED (Type or print) First <i>HOWARD</i> Middle <i>E.</i> Last <i>GRIMM</i>		4. DATE OF DEATH Month <i>April</i> Day <i>20</i> Year <i>1961</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB. 9 1895</i>
9. AGE (In years lost birthday) <i>66</i> yrs		10. IF UNDER 1 YEAR: Months <i>21</i> Days <i>10</i> Hours <i>06</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Care Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto.</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Grimm</i>		14. MOTHER'S MAIDEN NAME <i>Ida Reynolds</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>213-07-9541</i>	
17. INFORMANT <i>Ida Reynolds</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEPATIC CIRRHOSIS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from <i>MARCH 3, 1961</i> to <i>APRIL 20, 1961</i> , that (I) (we) last saw the deceased alive on <i>APRIL 10 1961</i> , and that death occurred at <i>4:30 P.M.</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Joseph Miceli</i>		22b. DATE SIGNED <i>4/24/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOSEPH MICELI, M.D.</i>		22d. ADDRESS <i>1085 TAYLOR AVE., BALTO. 21, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4-24-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>GARDENS OF FAITH</i>		23d. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Connolly</i>		25a. REC'D BY REGISTRAR <i>APR 25 '61</i>	
ADDRESS <i>418 Eastern Blvd Balto 21 Md</i>		25b. REGISTRAR'S SIGNATURE <i>Walter L. Thomas</i>	



CERTIFICATE OF DEATH

Reg. Dist. No.

03954

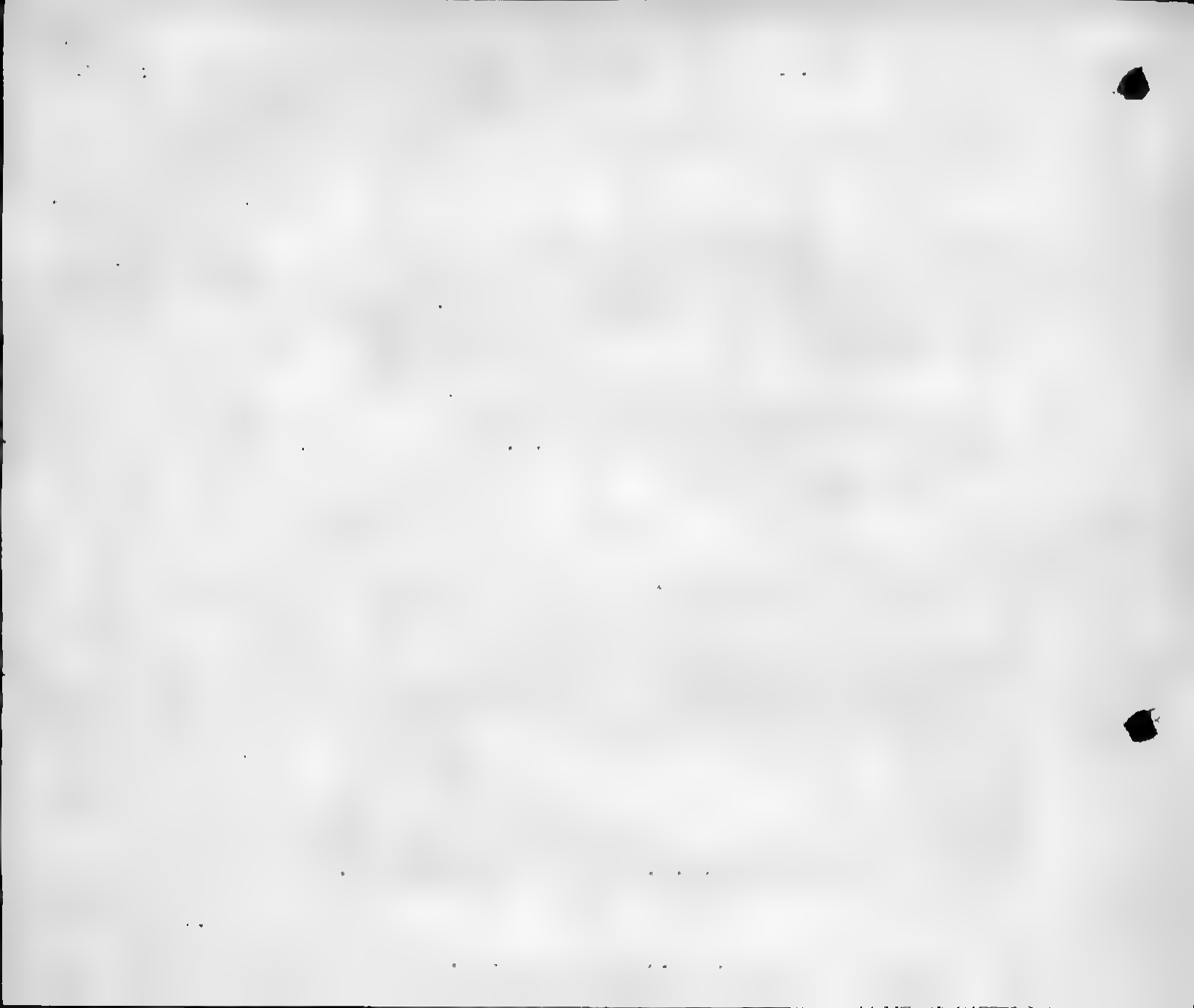
2060

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 14 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4128 Beachwood Road		e. STREET ADDRESS 4128 Beachwood Road	
3. NAME OF DECEASED (Type or print) First Middle Last JEANNETTE CATHERINE HAGUE		4. DATE OF DEATH Month Day Year April 4th, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1898
9. AGE (In years last birthday) yrs 62		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin A. Fisher		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Address W.H. Hague same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Basilar artery occlusion DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 5 months 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-15- 19 59 , to 4-4- 19 61 , that I lost saw the deceased alive on 4-3- 19 61 , and that death occurred at 3:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Mornington Road DATE SIGNED 4/5/61			
ACTUAL SIGNATURE Eugene F. Nevy M.D.		PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D. Baltimore 22, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/8/61	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md		24a. REC'D BY REGISTRAR APR 7 '61	
24b. REGISTRAR'S SIGNATURE C. Aug. L. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2961
CERTIFICATE OF DEATH
03955

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b LIFETIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 Reisterstown Road				d. STREET ADDRESS 1708 Reisterstown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Agnes Last Mahn				4. DATE OF DEATH Month April Day 29 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1888		9. AGE (in years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hemery Roschen				14. MOTHER'S MAIDEN NAME LOUISE AGNES SCHAEFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 312-03-9388		17. INFORMANT Mr. Irvin H. Mahn, 708 Reisterstown Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 114X DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) carcinomatosis (c) carcinoma of the uterus						INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 60 to Apr. 19 61 , that (I) (we) last saw the deceased alive on Apr. 28, 19 61 , and that death occurred at 10AM , from the causes and on the date stated above							
22a. SIGNATURE Gerald N. Maggid, M.D.				22b. ADDRESS Pikesville, Md.		22c. DATE SIGNED 4/24/61	
22c. PHYSICIAN'S NAME (Type) Gerald N. Maggid, M.D.				22d. ADDRESS Pikesville, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-61		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville Md	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Hargwell - Pikesville, Md.				25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Robert S. Thomas	

MEDICAL CERTIFICATION



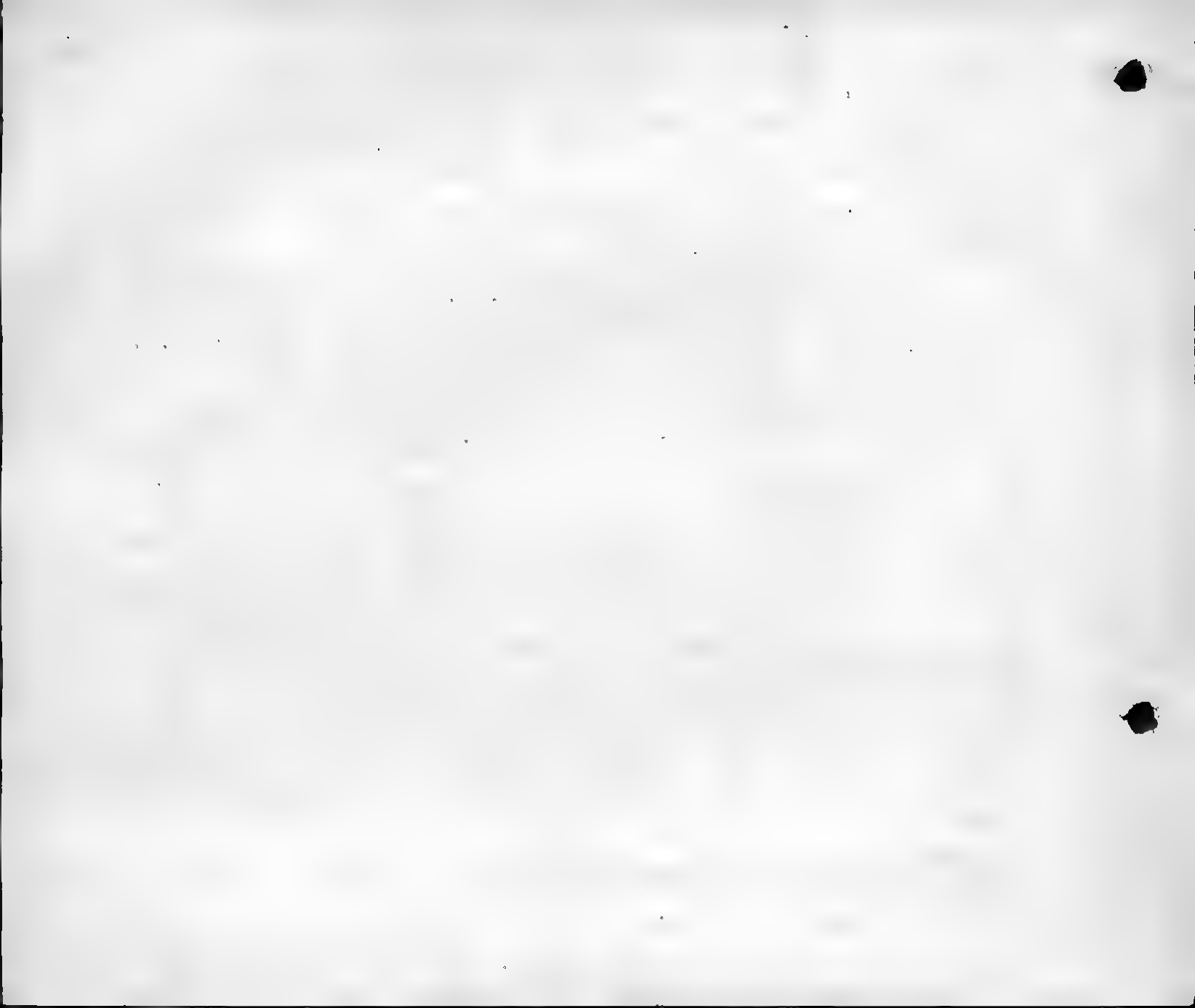
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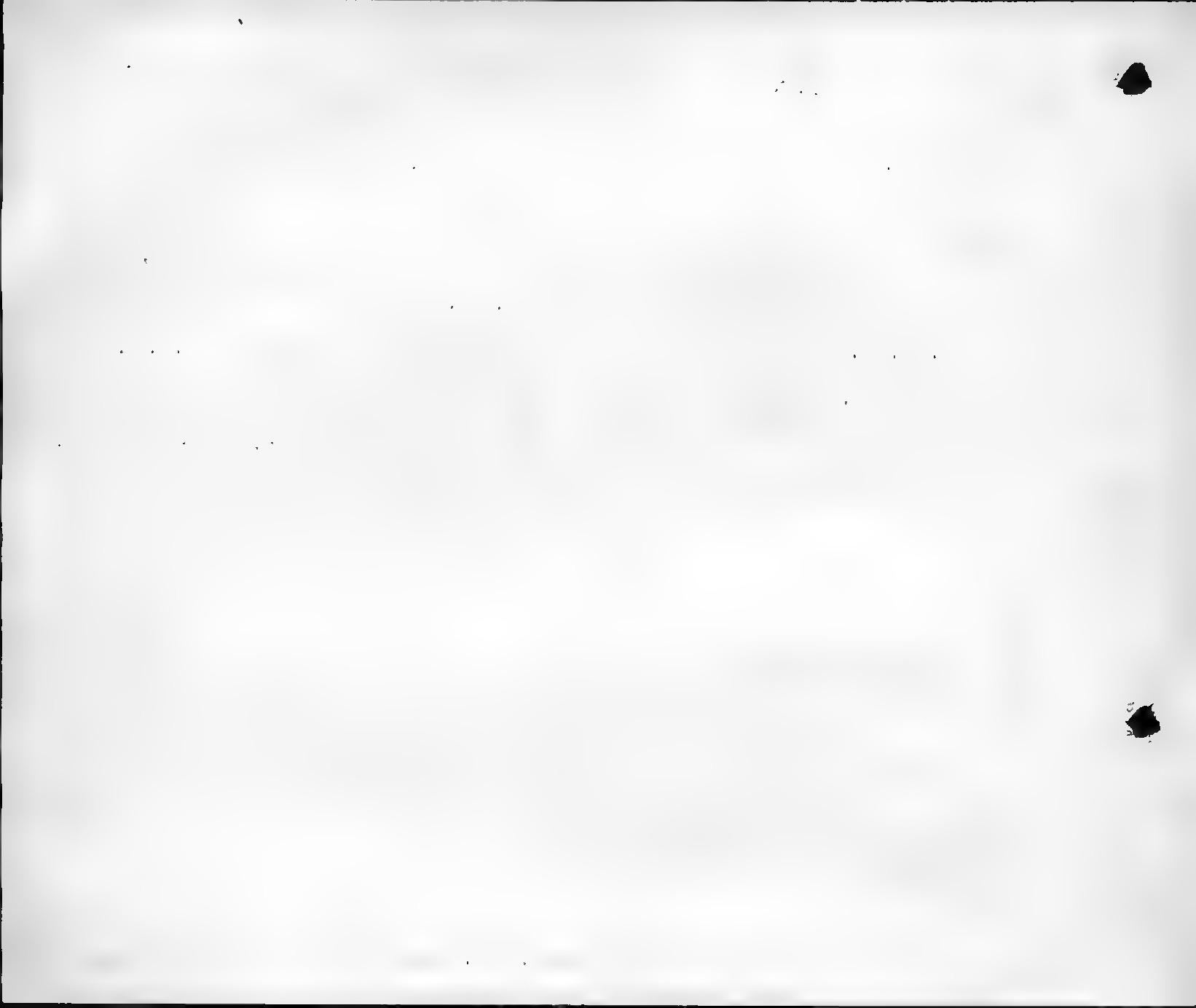
CERTIFICATE OF DEATH

Reg. Dist. No. 03956

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beaumont Nursing Home</u>		d. STREET ADDRESS <u>800 Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>William Edward Hammond</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Masonic Temple</u>	
11. BIRTHPLACE (State or foreign country) <u>West River Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hammond</u>		14. MOTHER'S MAIDEN NAME <u>Annie Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>216-01-6778</u>		17. INFORMANT <u>Elois N. Walker-2314 Druid Hill Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> DUE TO <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>4-25-61</u> to <u>4-27-61</u> , that I last saw the deceased alive on <u>4-26-61</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Reisterstown Md.</u> DATE SIGNED <u>4-30-61</u> ACTUAL SIGNATURE <u>Herbert L. Nutter</u> M.D. <u>Reisterstown Md.</u> PHYSICIAN'S NAME (Type) <u>Herbert L. Nutter</u> <u>Reisterstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/1/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert L. Nutter-3035 N. North Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03958

3064

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		d. STREET ADDRESS Glenarm Road	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Hugh Hauser		4. DATE OF DEATH Month Day Year April 11 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	11. BIRTHPLACE (State or foreign country) Jersey City, N.J.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME August Hauser	
14. MOTHER'S MAIDEN NAME Margaret Fried		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Sister M. Peter Fourier Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma of lung 153.9 DUE TO Carcinoma of bowel Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 19 53 to April 19 61 , that I last saw the deceased alive on April 11 19 61 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Road Towson 4, Md. 4/11/61			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-13-61	22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.	22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR. TOWSON, MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Jailer</i>		24a. REC'D BY REGISTRAR DATE APR 13 '61	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician has been signed by the attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

2065

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03959

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. LENGTH OF STAY IN 1b <u>Essex (21)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2117 Middleborough Rd.</u>				d. STREET ADDRESS <u>2117 Middleborough Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>RICHMOND</u> Last <u>HAYES</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1887</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Inds.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stewart MacKay</u>				14. MOTHER'S MAIDEN NAME <u>Martha ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>172-10-9892A</u>		17. INFORMANT <u>Richmond Kershaw</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO <u>Myocardial Ischemic Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Gen. Arterio Sclerosis</u> (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>4 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Myeloma</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack P. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack P. Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdinski</u>				ADDRESS <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur P. K...</u>			

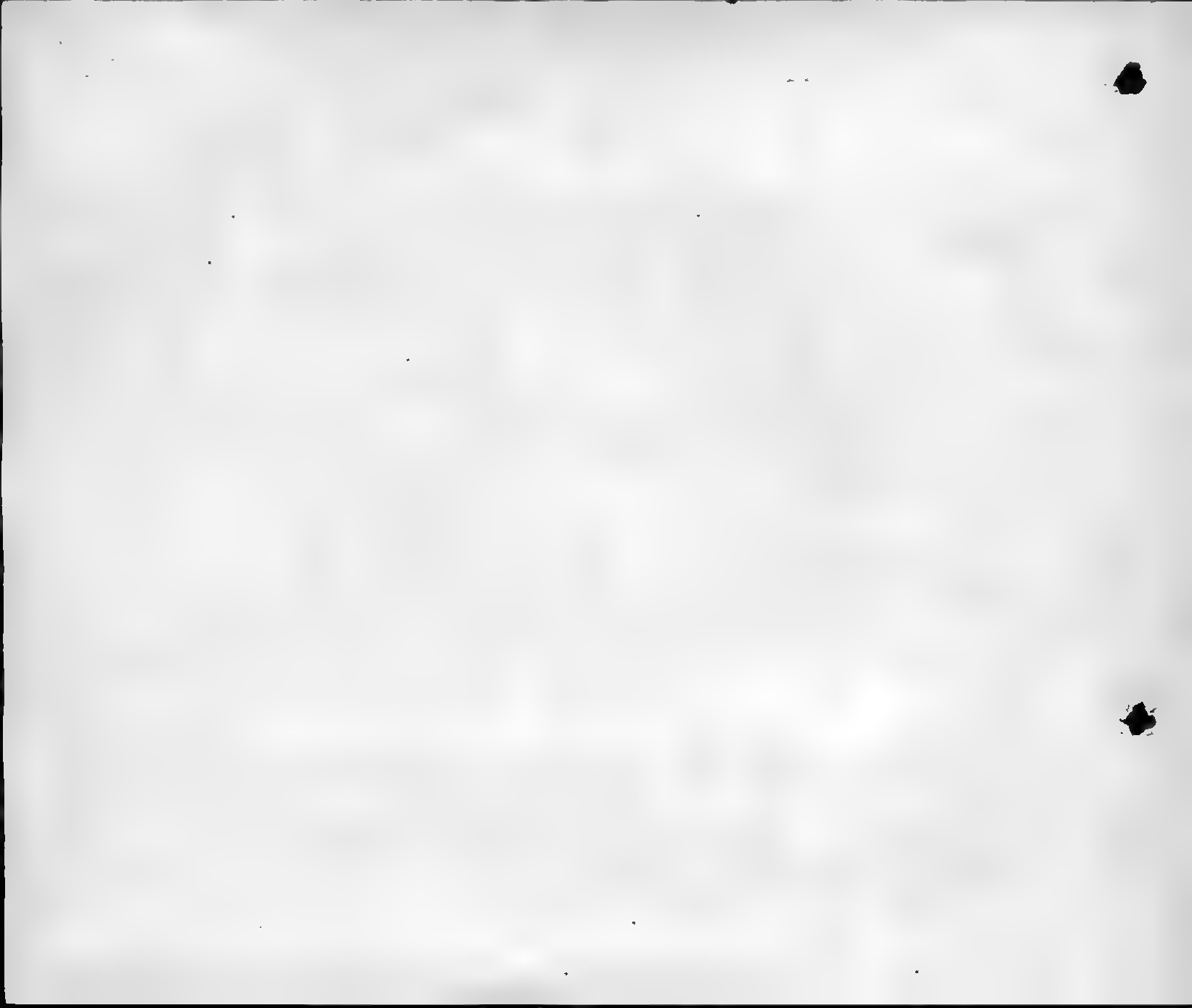
MEDICAL CERTIFICATION

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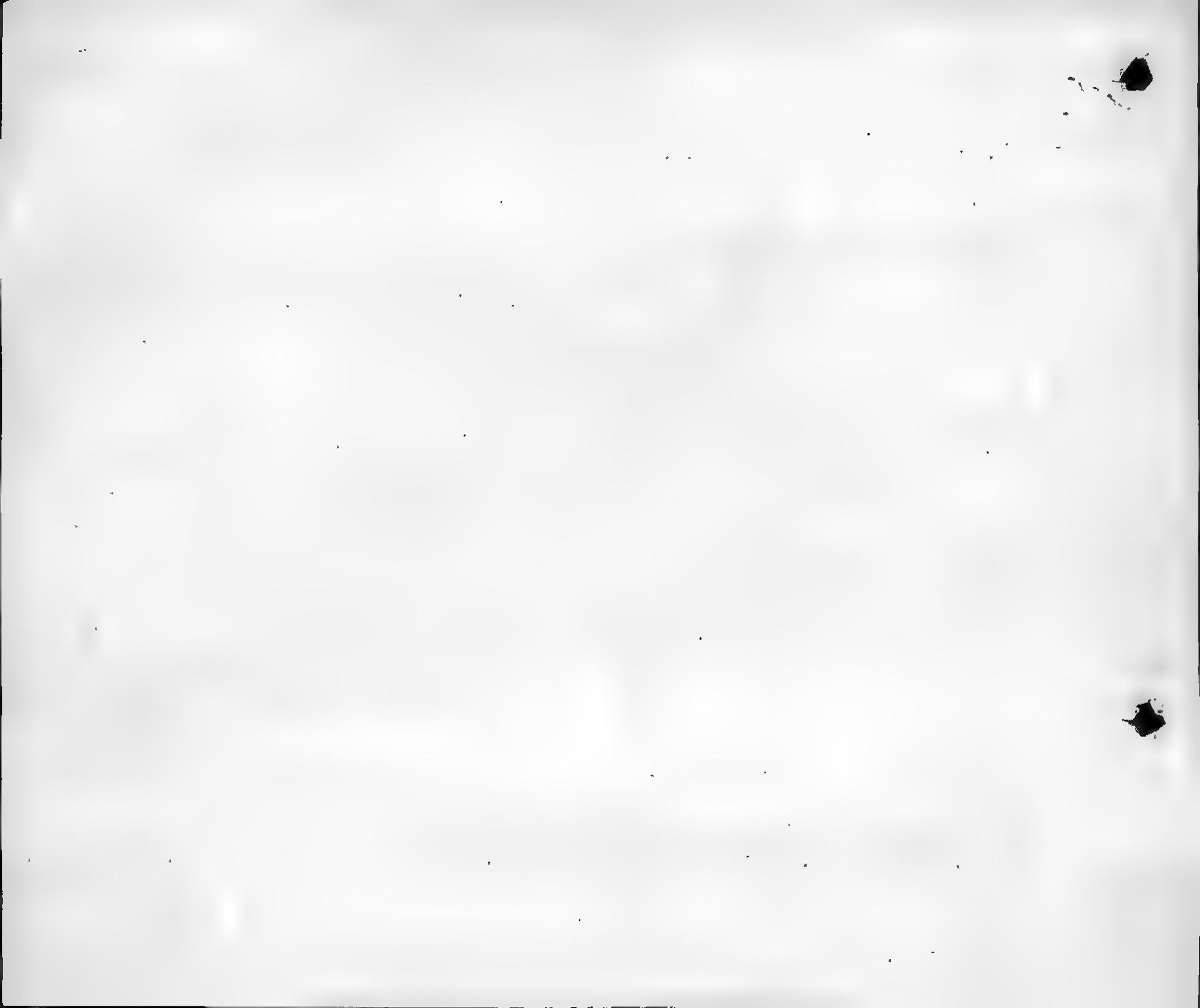
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician. IF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 11/59

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3366
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03960

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 11 mo. 13 da.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4503 Gretna St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Georgia Sive Hecht		4. DATE OF DEATH Month Day Year 4 13 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1904
9. AGE (In years last birthday) 36 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Millinery	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chapman Sive		14. MOTHER'S MAIDEN NAME Mary E. Dyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 011-14-7899	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 18 mo. (c) 18 mo.		INTERVAL BETWEEN ONSET AND DEATH 18 mo.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pyelonephritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/29, 1960 to 4/13, 1961 , that (I) (we) last saw the deceased alive on 4/13, 1961 , and that death occurred at 8:25 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 4/13/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Rumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass		25c. DATE APR 17 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

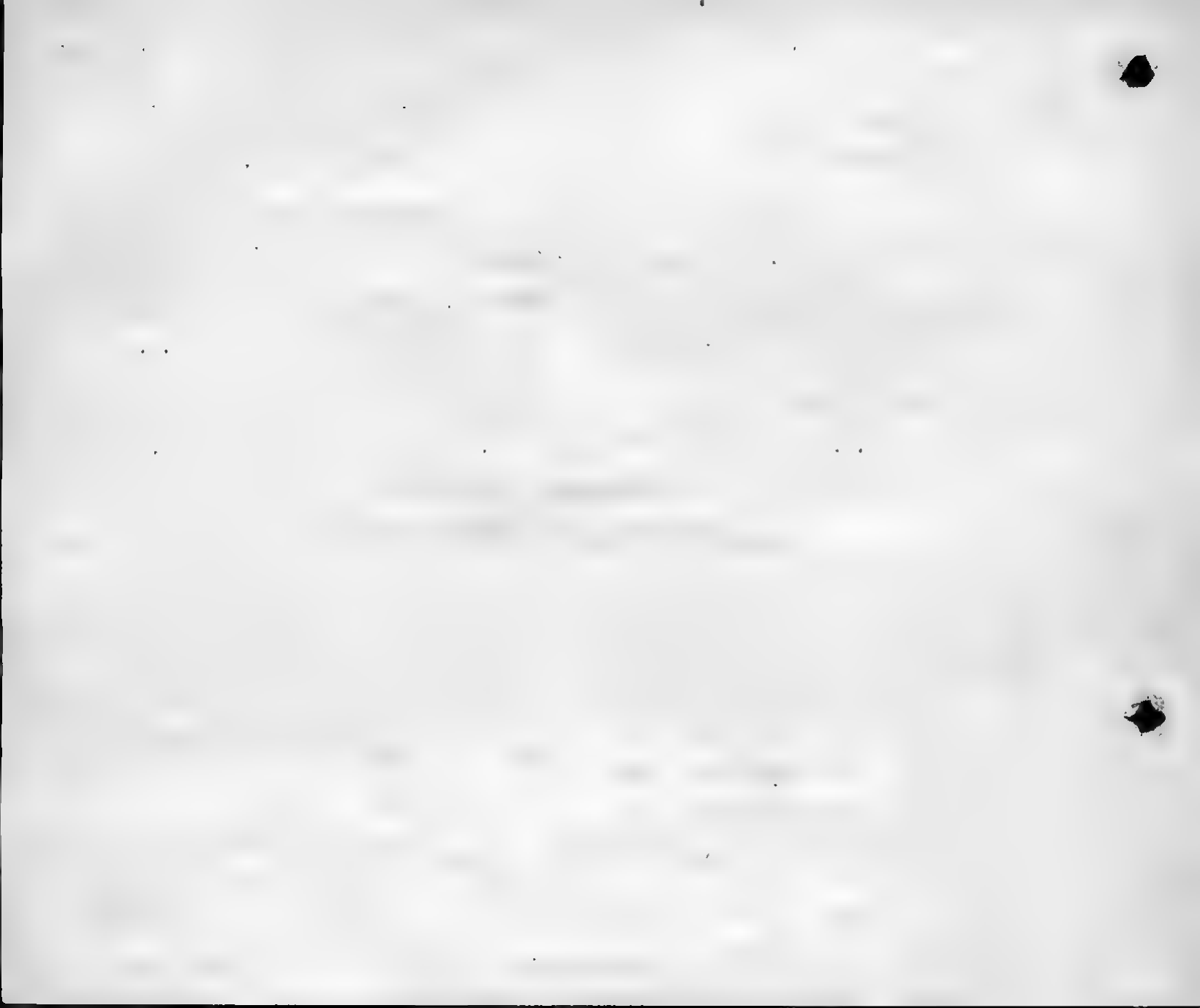
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3367

03961

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 715 Woodsdale Ave. d. STREET ADDRESS Catonsville 28 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) T. Bernard Heilmann First Middle Last		4. DATE OF DEATH April 17 1961 Month Day Year	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1890 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier 10b. KIND OF BUSINESS OR INDUSTRY Dairy-Retired 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Heilmann 14. MOTHER'S MAIDEN NAME Matter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.I 16. SOCIAL SECURITY NO 216-03-6578 17. INFORMANT Alice M. Heilmann-715 Woodsdale Ave.-28- Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary Occlusion DUE TO (b) Generalized Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): INTERVAL BETWEEN ONSET AND DEATH 15 min 59 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 1930 to April 17 1961, that (I) (we) last saw the deceased alive on April 12 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wetherbee Fort 22c. PHYSICIAN'S NAME (Type) Wetherbee Fort		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 6500th Ave - Catonsville 28. Md	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 4--20--1961 23c. NAME OF CEMETERY OR CREMATORY Moreland Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Max North + Son ADDRESS 301 Frederick Ave; 28		25a. REC'D BY REGISTRAR APR 20 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

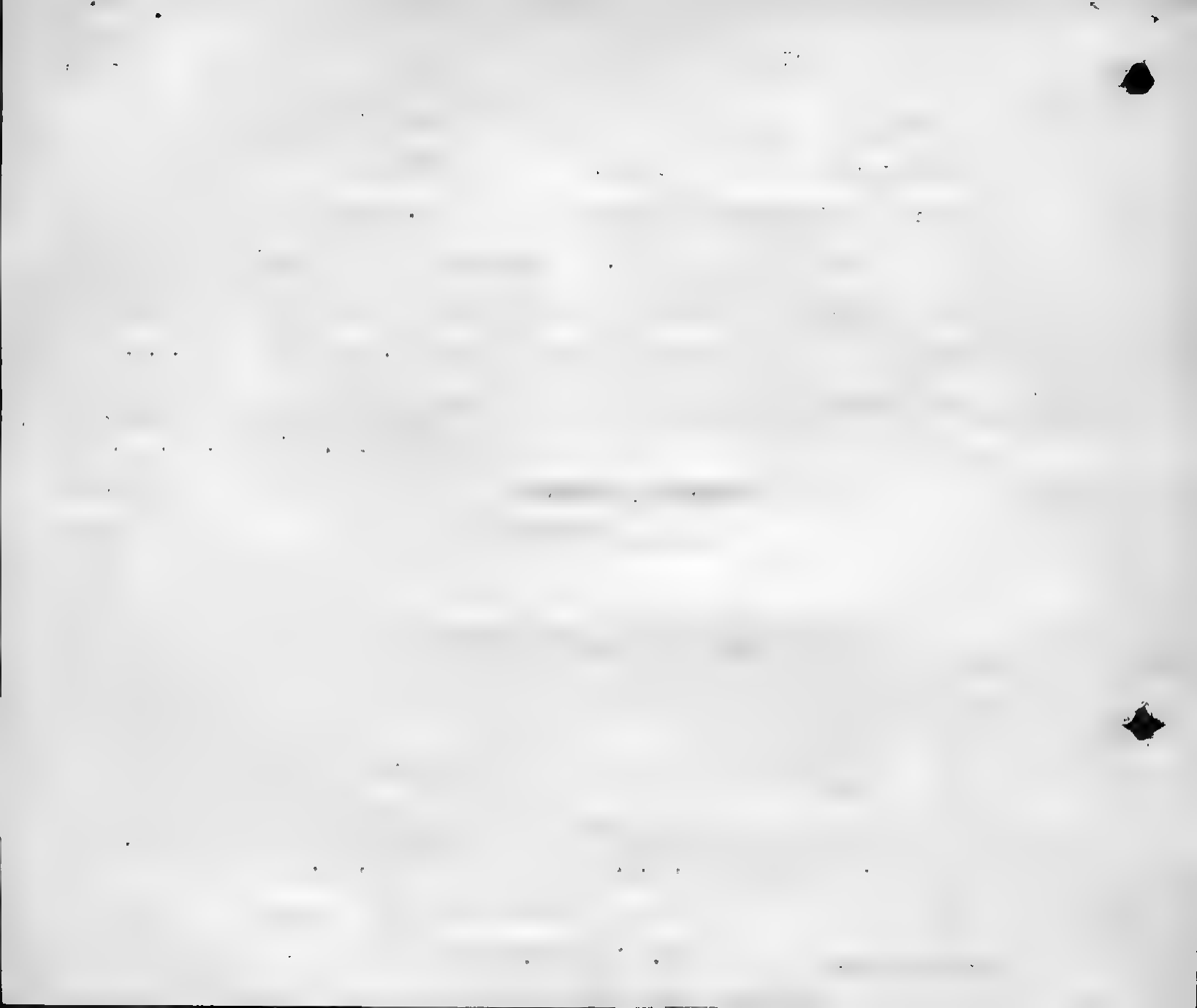
VR AIS (4)
ISM 9/60

3968

3962

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore 13 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1809 N. Durham Street d. STREET ADDRESS 1809 N. Durham Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL J. HERFURTH		4. DATE OF DEATH April 22 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH March 20, 1897		9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Distillery Company, Curtis Bay, Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Karl Herfurth		14. MOTHER'S MAIDEN NAME Josephine Zaruka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11		16. SOCIAL SECURITY NO. 3900 Loch Raven Blvd. Balto 18, Md. FT. HOWARD	
17. INFORMATION Clinical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE CEREBRAL HEMORRHAGE 331X DUE TO CEREBRAL ARTRIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiovascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year April 19 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that A (this hospital) attended the deceased from April 19 1961 to April 22 1961 that A (we) last saw the deceased alive on April 22 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE M. Lawrence Rubin, M.D.		22b. DATE SIGNED 4/22/61	
22c. PHYSICIAN'S NAME (Type) M. LAWRENCE RUBIN, M.D.		22d. ADDRESS VAH, 3900 Loch Raven Blvd. Baltimore 18, Md. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11 26 1961	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leo Cook & Son		25a. REC'D BY REGISTRAR APR 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03963

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN TB <u>25 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Cypress Ct</u>		d. STREET ADDRESS <u>101 Cypress Ct 1</u>	
3. NAME OF DECEASED (Type or print) <u>Novella</u> First <u>Virginia</u> Middle <u>Ettil</u> Last <u>1</u>		4. DATE OF DEATH <u>April</u> Month <u>7</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 2, 1909</u>
9. AGE (In years last birthday) <u>51</u> yrs		10. IF UNDER 1 YEAR <u>7</u> Months <u>2</u> Days <u>—</u> Hours <u>—</u> M. n. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAIATE Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Holland, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Willie Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Georgie Sumblor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-23-374</u>	
17. INFORMANT <u>Hortense Henry</u> Address <u>108 N. Benton St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> X DUE TO <u>HyperTension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>46</u> to <u>April 4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>61</u> , and that death occurred at <u>8:30</u> P. M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>William C. Wade</u> M.D.		ADDRESS (Street, city, or town, state) <u>1400 Gt Avenue E</u> DATE SIGNED <u>4-4-61</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-9-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Holland, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue, Balto., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03964

2070

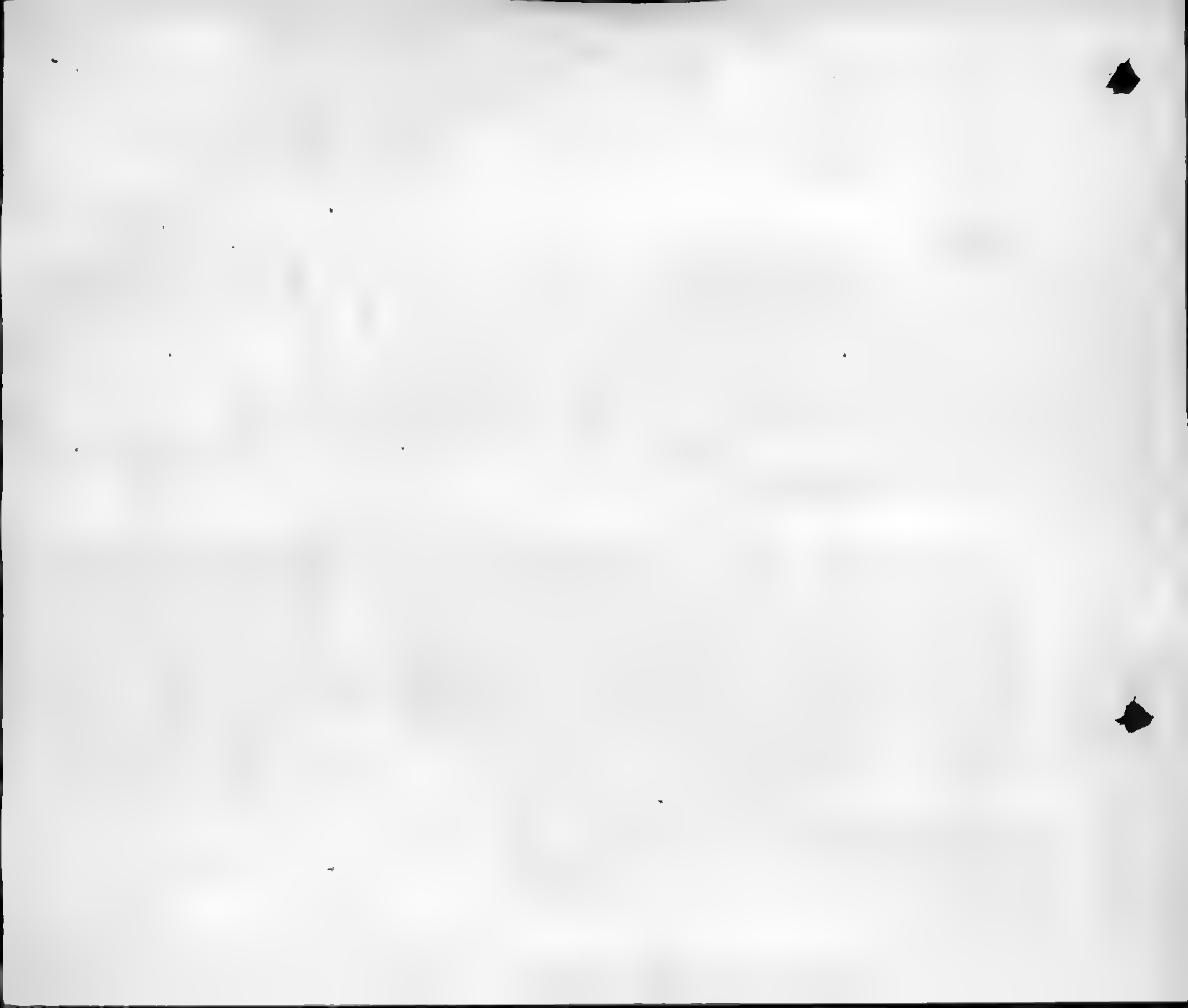
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

(M)

(I)

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 43 Wade Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle OWEN Last HILTON		4. DATE OF DEATH Month April Day 17 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2--24--1902
9. AGE (in years and birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transit Co.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas O. Hilton	
14. MOTHER'S MAIDEN NAME Rachel Ewald		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 213-10-2512		17. INFORMANT Address Mrs Myrtle H. Hilton 43 Wade Ave-28- Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-0-1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) gave rise to the underlying cause underlying cause lost (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE GEO. S. M. KIEFFER, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 17 1961	
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1610 Leads on	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-20--1961	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. M. M. M.		24a. REC'D BY REGISTRAR 301 Frederick Road 28	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03965

1. PLACE OF DEATH a. COUNTY Baltimore County		b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 4 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 3609 DUDLEY AVENUE	
3. NAME OF DECEASED (Type or print) First CARROLL Middle PETER Last HOBBES		4. DATE OF DEATH Month APRIL Day 7 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 19 1901
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKERY SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY BREAD AND PASTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL HOBBES		14. MOTHER'S MAIDEN NAME MARY GRIMES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-6430	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 02X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 9 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/20 to 4-7 19 61 , that (I) (we) lost the deceased alive on 4-7 19 61 , and that death occurred at 5:30 P. M. from the causes and on the date stated above			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md	
23a. BURIAL CREMATION, REMOVAL (Specify) 4-11-61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S Cem		23d. LOCATION (City, town, or county) (State) BALTO MD.	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck, Inc - 5305 Harford Rd		25a. REC'D BY REGISTRAR APR 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03966

3972

<p>1. PLACE OF DEATH & COUNTY <i>Baltimore</i></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eatonville</i></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>House in Pines 16 Rustling Ave</i></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>MD</i> b. COUNTY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i></p> <p>d. STREET ADDRESS <i>636 Wildwood</i></p>	
<p>3. NAME OF DECEASED (Type or print) <i>Lena E. Hook</i></p>		<p>4. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1961</i></p>	
<p>5. SEX <i>Female</i></p> <p>6. COLOR OR RACE <i>W</i></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>Jan. 8, 1898</i></p> <p>9. AGE (In years last birthday) <i>63</i> yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i></p> <p>13. FATHER'S NAME <i>Wm. A. Beery</i></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i></p> <p>11. BIRTHPLACE (County & State or foreign country) <i>Pa. Md.</i></p> <p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p> <p>14. MOTHER'S MAIDEN NAME <i>Eugenia Lynn</i></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p> <p>16. SOCIAL SECURITY NO. <i>Sebastian H. Hook</i></p>		<p>17. INFORMANT <i>Sebastian H. Hook</i></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized carcinomatosis</i> DUE TO (b) <i>Carcinoma of left breast</i> Conditions, if any, which gave rise to immediate cause (c) <i>4/1/1960</i></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 11, 1960</i> to <i>Apr. 7, 1961</i> that (I) (we) last saw the deceased alive on <i>Apr. 7, 1961</i>, and that death occurred at <i>2:40 P.M.</i> from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <i>George A. Knipp</i></p>		<p>22b. DATE SIGNED <i>Apr 8 1961</i></p>	
<p>22c. PHYSICIAN'S NAME (Type) <i>George A. Knipp</i></p>		<p>22d. ADDRESS <i>4116 Edmondson Ave</i></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>23b. DATE THEREOF <i>4/10/61</i></p>	
<p>23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Pk.</i></p>		<p>23d. LOCATION (City, town or county) (State) <i>Wicoma, Md.</i></p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke F.W.</i></p>		<p>25a. REC'D BY REGISTRAR DATE <i>APR 10 '61</i></p>	
<p>25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i></p>		<p>25c. ADDRESS <i>4101 Edmondson</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2973

Item 9 Film G-04 4/15/61 1wk

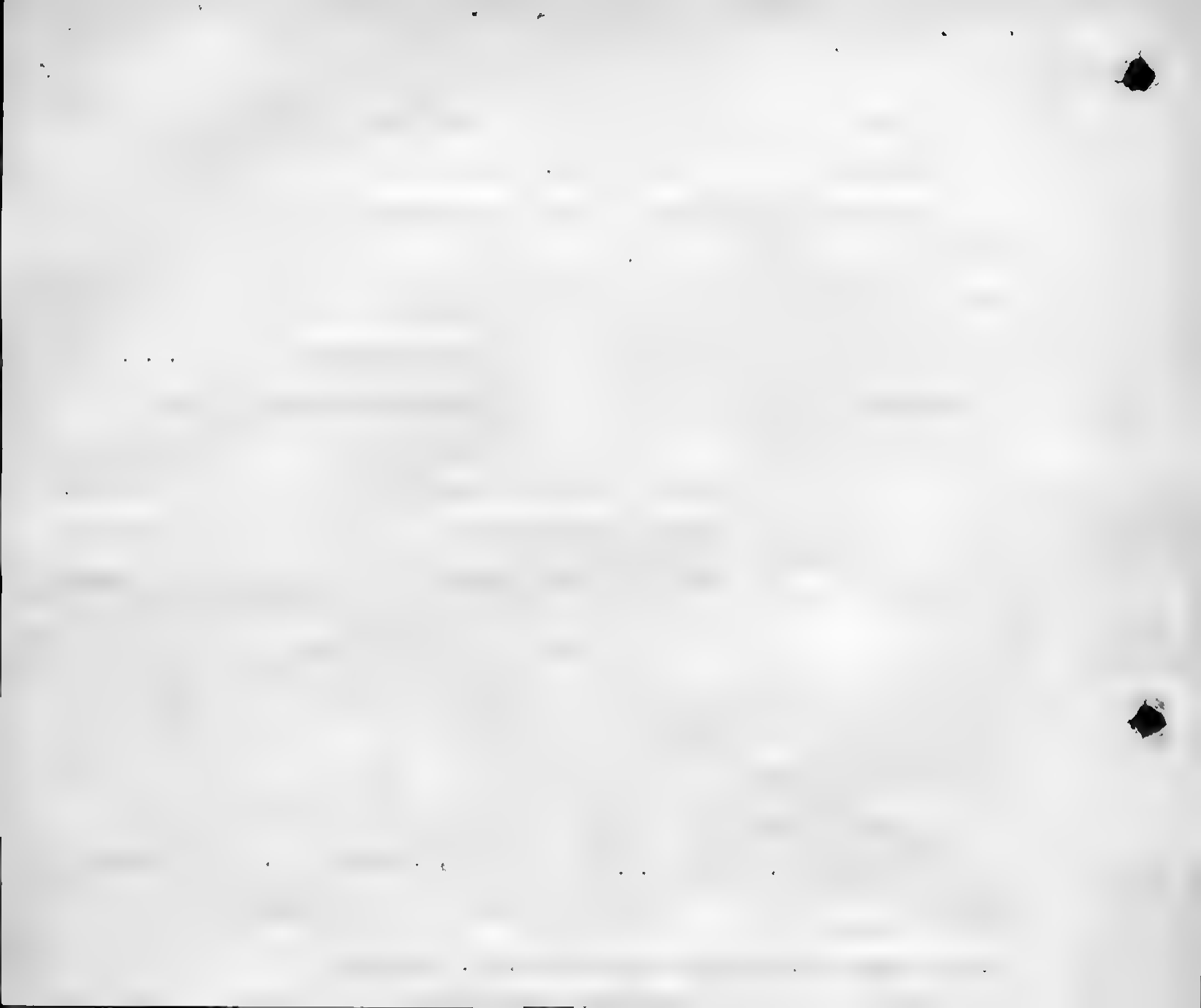
CERTIFICATE OF DEATH

08967

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN b 28 hrs 15 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 3137 Eastern Avenue	
3. NAME OF DECEASED (Type or print) BUSTER T. HOWARD		4. DATE OF DEATH Month APRIL Day 5 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1916
9. AGE (in years last birthday) 44 1/2 yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House Painter	
11. BIRTHPLACE (County & State, or foreign country) Lexington, Alabama		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James Howard		14. MOTHER'S MAIDEN NAME Susan (Maiden Name Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number of service) Yes WW PL 28		16. SOCIAL SECURITY NO. 524-01-2630	
17. INFORMANT Clin. Records, VAH, Balto. Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH (Enter only one cause per I for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ESSENTIAL HYPERTENSION BRONCHOPNEUMONIA, RECENT		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from April 4, 1961 to April 5, 1961 , that (X) (we) last saw the deceased alive on April 5, 1961 , and that death occurred 3:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan, M.D.		22b. DATE SIGNED 4/6/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE, MD. FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-10-61	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City, town or county) (State) BALTIMORE 28, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight, Inc.		25a. REC'D BY REGISTRAR APR 10 '61	
ADDRESS 6009 Harford Rd. Balto. Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3974

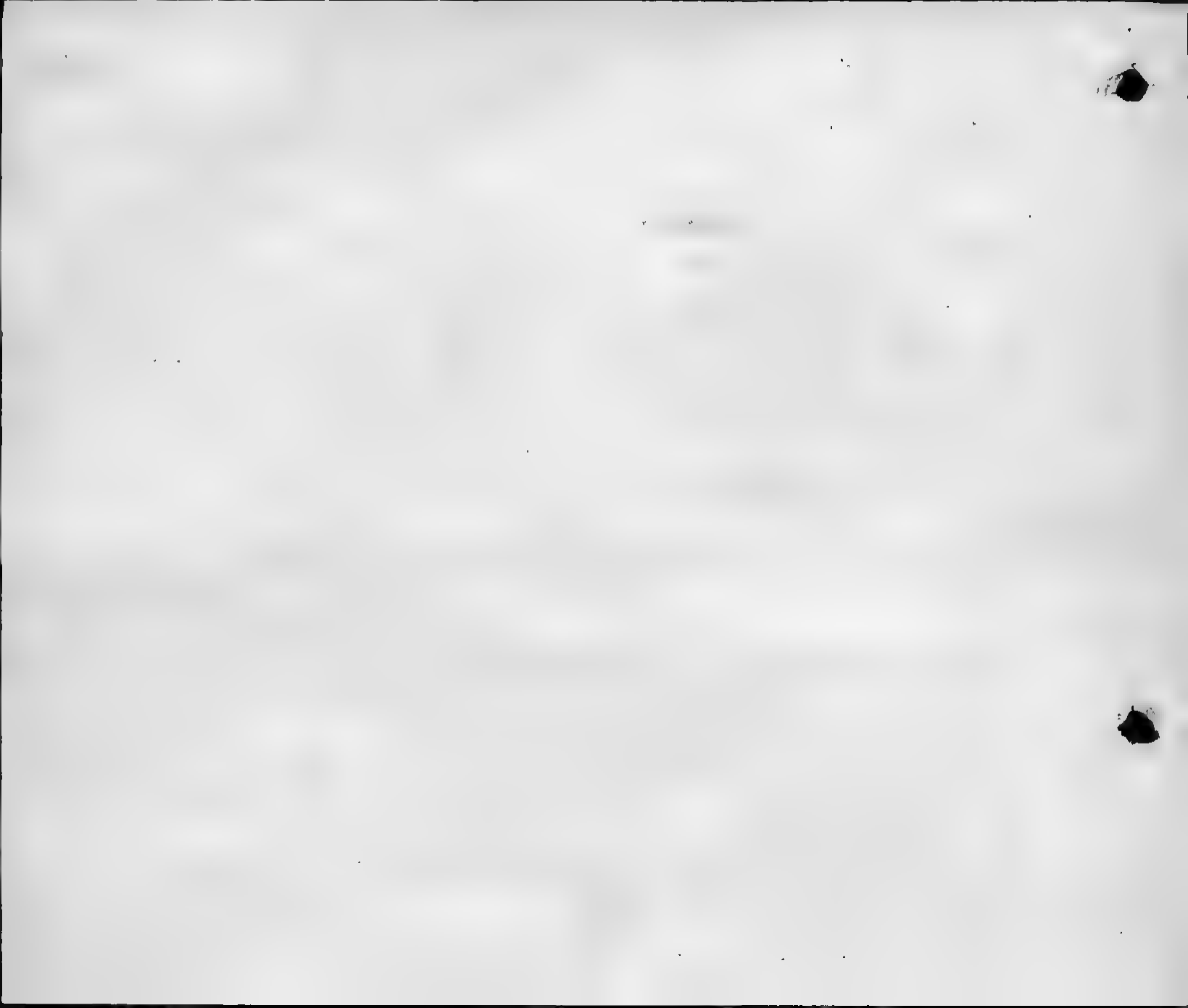
Items 1 & 2 Film G286

CERTIFICATE OF DEATH

iwk

03968

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Anne Arundel County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> c. LENGTH OF STAY IN town <u>1713 Wilson Avenue, A/K/A/Col</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1713 Wilson Avenue, A/K/A/Col</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland, Anne Arundel Baltimore Co.</u> b. COUNTY <u>Arbutus</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>3116 Hilltop Av.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fannie J. Howard</u>		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/30/1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
13. FATHER'S NAME <u>John Doffmyer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Edna Hill, 3116 Hilltop Av.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) <u>Advance of Generalized Arteriosclerosis</u> DUE TO (c) <u>Parkinson's Disease due to Corbular Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Parkinson's Disease due to Corbular Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>7 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>April 14, 1955</u> to <u>April 25, 1961</u> , that (I) (was) last saw the deceased alive on <u>April 22, 1961</u> , and that death occurred at <u>4:00 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Arthur Rosenberg M.D.</u>		22b. DATE SIGNED <u>4/26/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSENBERG MD</u>		22d. ADDRESS <u>2436 WASHINGTON Blvd. Balto. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		23d. LOCATION (City, town or county) (State) <u>Anne Arundel Co.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd. (14)</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

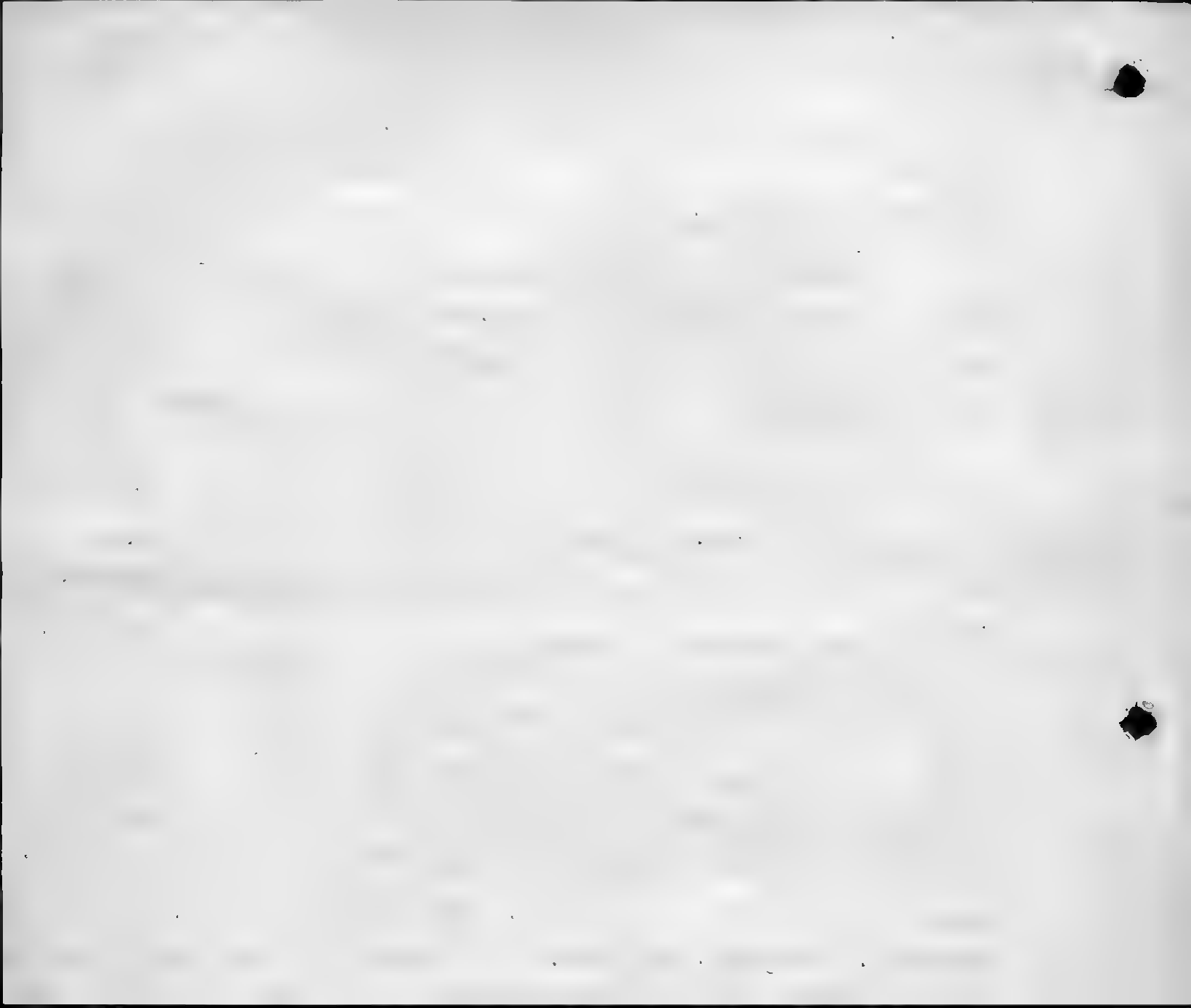
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3975

03969

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2529 Canterbury Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>12529 Canterbury Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Augusta</u> First Middle Last 4. DATE OF DEATH <u>4-24-1961</u> Month Day Year 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 1, 1888</u> 9. AGE (In years last birthday) <u>73</u> yrs. F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>August Templin</u> 14. MOTHER'S MAIDEN NAME <u>Wilhelmina (Unknown)</u> Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. 17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia, Acute, Severe</u> DUE TO (b) <u>Coma, Deep</u> DUE TO (c) <u>Arteriosclerosis Generalized (Especially Cerebral)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, severe, esp. left hip; (b) Decubiti, severe, multiple</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u> <u>36 Hrs.</u> <u>2 1/2 Hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/10/1961</u> to <u>4/23/1961</u> , that (I) (we) last saw the deceased alive on <u>4/23/1961</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Edward L. Molz</u> M.D. 22b. DATE SIGNED <u>24 April 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>Edward L. J. Molz, M.D.</u> 22d. ADDRESS <u>7425 Harford Rd. Balto. 14 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>4-27-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u> 23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u> 25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	



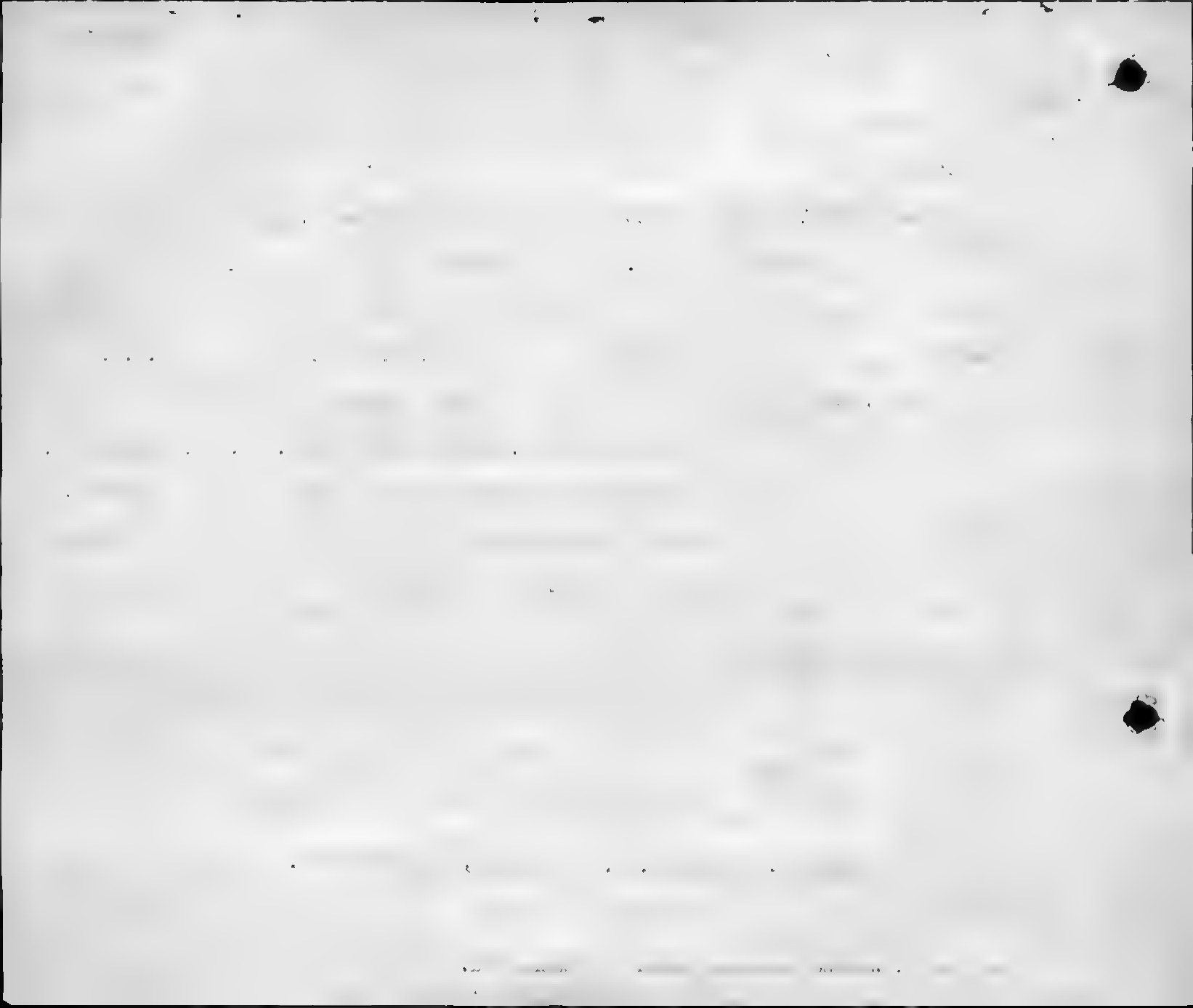
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 05370

2276

1. PLACE OF DEATH a. COUNTY <p style="text-align: center;">Baltimore</p> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Fort Howard</p> c. LENGTH OF STAY IN 1b <p style="text-align: center;">83 days</p> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <p style="text-align: center;">Veterans Administration Hospital</p>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <p style="text-align: center;">Maryland</p> b. COUNTY <p style="text-align: center;">Baltimore</p> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Baltimore</p> d. STREET ADDRESS <p style="text-align: center;">1727 Madison Avenue</p>	
3. NAME OF DECEASED (Type or print) <p style="text-align: center;">ARTHUR R. JOHNSON</p>		4. DATE OF DEATH Month Day Year <p style="text-align: center;">April 11 19 61</p>	
5. SEX <p style="text-align: center;">Male</p>		6. COLOR OR RACE <p style="text-align: center;">Negro</p>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <p style="text-align: center;">January 1896</p>	
9. AGE (In years last birthday) <p style="text-align: center;">65 yrs</p>		10. UNDER 1 YEAR Months Days 	
11. IF UNDER 24 HRS Hours Min. 		12. CITIZEN OF WHAT COUNTRY <p style="text-align: center;">U.S.A.</p>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">Laborer</p>		10b. KIND OF BUSINESS OR INDUSTRY <p style="text-align: center;">Construction</p>	
11. BIRTHPLACE (County & State, or foreign country) <p style="text-align: center;">Baltimore, Maryland</p>		12. CITIZEN OF WHAT COUNTRY <p style="text-align: center;">U.S.A.</p>	
13. FATHER'S NAME <p style="text-align: center;">Harry Johnson</p>		14. MOTHER'S MAIDEN NAME <p style="text-align: center;">Fanny Grant</p>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <p style="text-align: center;">Yes WW I</p>		16. SOCIAL SECURITY NO <p style="text-align: center;">218-07-5865</p>	
17. INFORMANT Address <p style="text-align: center;">Clin. Records, VAH, Balto. Md. Ft. Howard Div.</p>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA RECENT DUE TO (b) CHRONIC PYELONEPHRITIS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center;">UNKNOWN</p>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <p style="text-align: center;">19</p>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that TH (this hospital) attended the deceased from January 18, 1961 , to April 11, 1961 , that TH (we) last saw the deceased alive on April 11, 1961 , and that death occurred at 8:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE <p style="text-align: center;"><i>Thomas F. Crahan</i> M.D.</p>		22b. DATE SIGNED <p style="text-align: center;">4/12/61</p>	
22c. PHYSICIAN'S NAME (Type) <p style="text-align: center;">THOMAS F. CRAHAN, M. D.</p>		22d. ADDRESS <p style="text-align: center;">VAH, BALTIMORE, MD. - FT HOWARD DIVISION</p>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <p style="text-align: center;">BURIAL</p>		23b. DATE THEREOF <p style="text-align: center;">4-17-61</p>	
23c. NAME OF CEMETERY OR CREMATORY <p style="text-align: center;">BALTIMORE NATIONAL</p>		23d. LOCATION (City, town or county) (State) <p style="text-align: center;">BALTIMORE 28, MARYLAND</p>	
24. FUNERAL DIRECTOR'S SIGNATURE <p style="text-align: center;">William A. Jackson Funeral Home, 3814 Bonner Rd.</p>		25a. REC'D BY REGISTRAR DATE APR 14 '61	
<p style="text-align: center;">Baltimore, Md.</p>		25b. REGISTRAR'S SIGNATURE <p style="text-align: center;"><i>Arthur S. Kraus</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

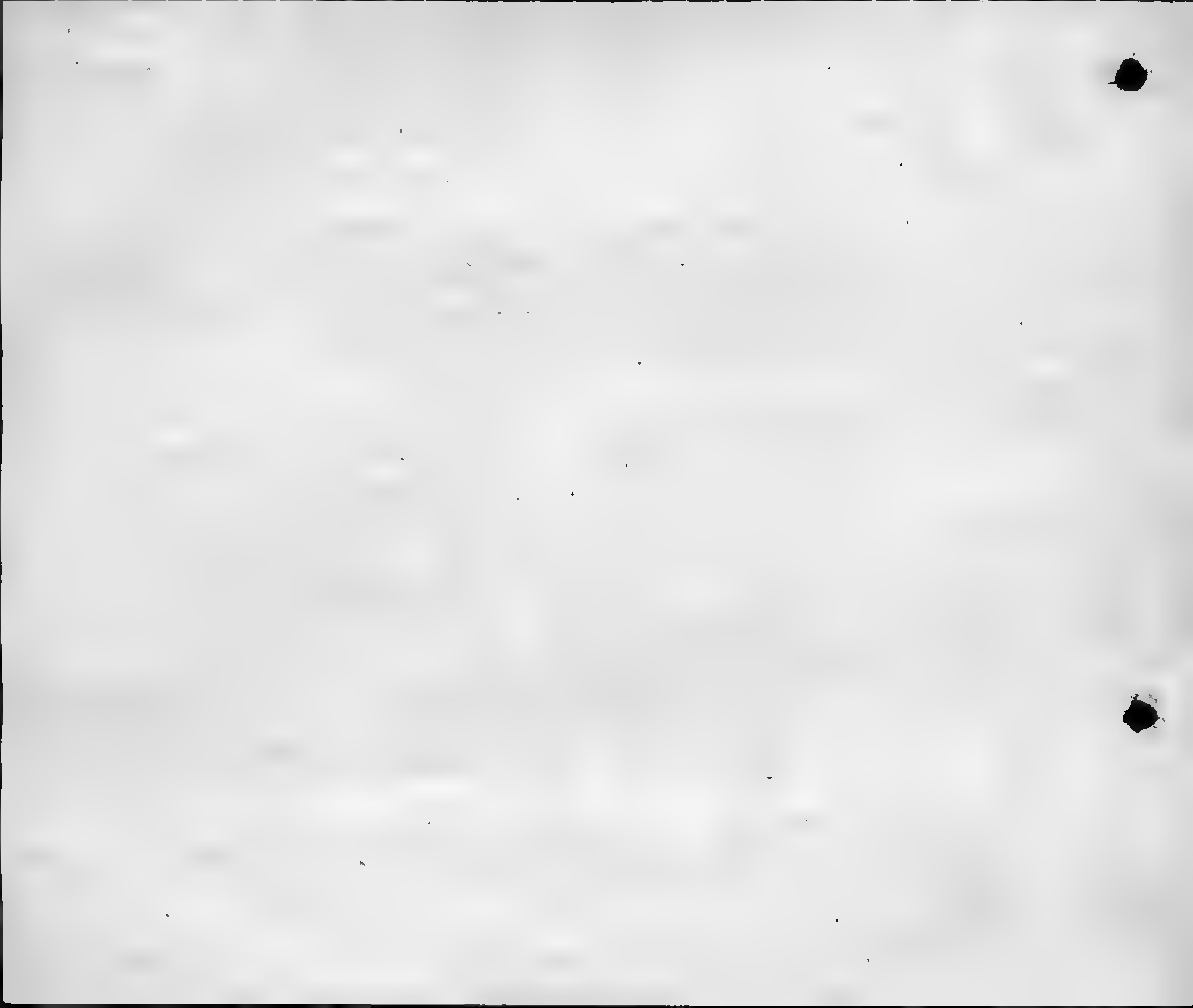
03971

Item 14 FILE 4205 4/24/61 jwk

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town <u>Parkville</u> c. LENGTH OF STAY in 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2617 Canterbury Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town <u>Parkville</u> d. STREET ADDRESS <u>2617 Canterbury Road</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha M. Johnson</u>		4. DATE OF DEATH <u>April 19th, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife & saleslady Dept. store</u>		10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bromwell</u>		14. MOTHER'S MAIDEN NAME <u>Leonor unknown</u>	
15. WAS ACCIDENT EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) _____		16. SOCIAL SECURITY NO. <u>219012470</u>	
17. INFORMANT <u>Ellsworth D. Johnson</u> Address _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <u>Obesity, moderately severe</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> _____ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) <u>(this physician)</u> attended the deceased from <u>30 July, 1952</u> to <u>19 April, 1961</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>8 April, 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward L. J. Molz, M.D.</u>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type, <u>Edward L. J. Molz, M.D.</u>)		22d. ADDRESS <u>7425 Harford Rd. Balto. 14 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-22-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>APR 24 '61</u>	
ADDRESS <u>5305 Harford Road #14</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

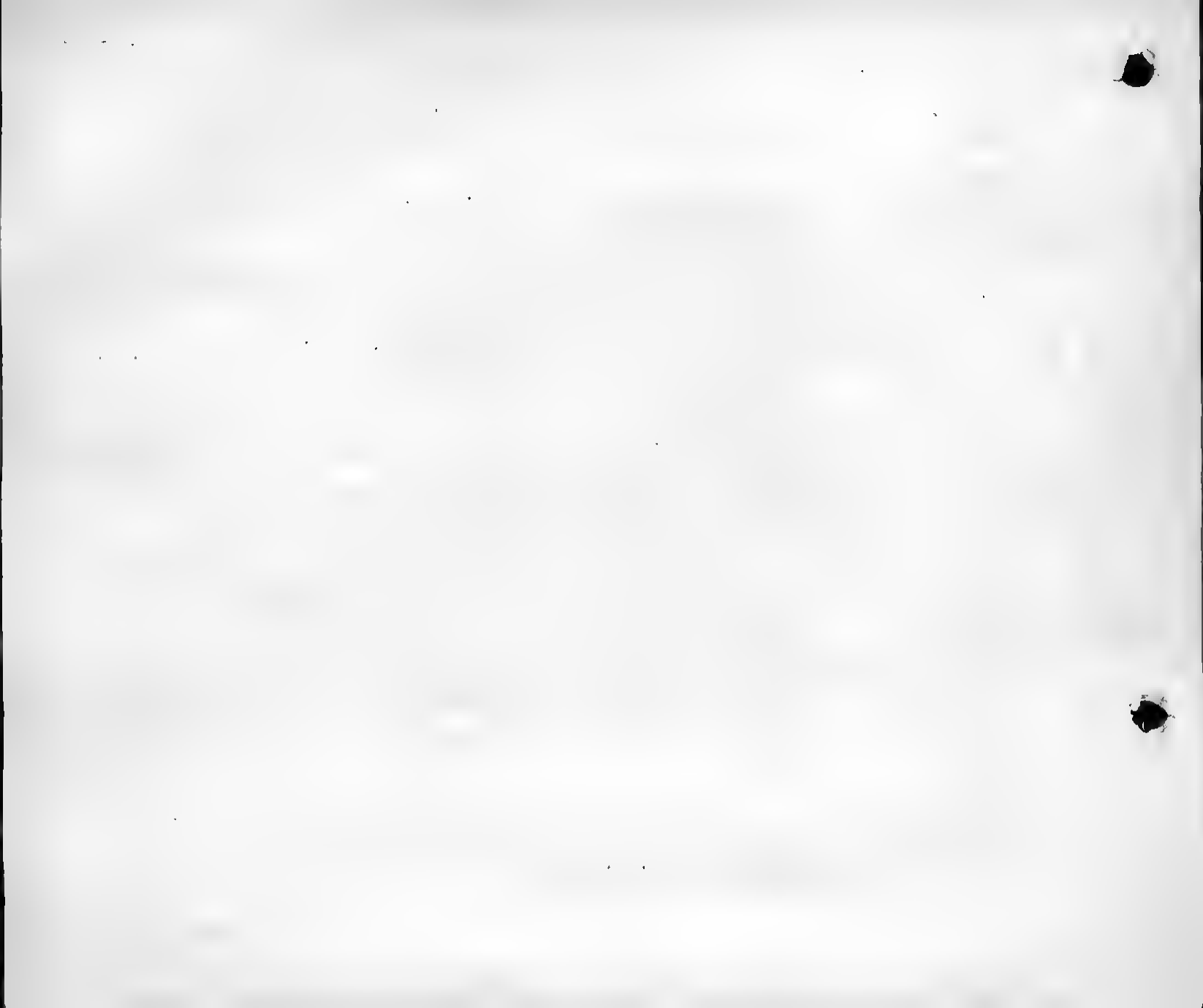
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2078

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u> <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>14</u> days			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clifton Johnson</u>				4. DATE OF DEATH Month Day Year <u>April 5 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 15, 1895</u>	
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Army</u> <u>unknown</u>				16. SOCIAL SECURITY NO <u>216-09-3561</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>Generalized arteriosclerosis</u> (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 21 9:00</u> to <u>April 5</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>April 5</u> , 19 <u>61</u> and that death occurred at <u>2</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar M. D.</u>				22b. DATE SIGNED <u>4-5-61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LONDON IR</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. 117-136 G Fort W.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>W. C. 117-136 G Fort W.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

03973

2079

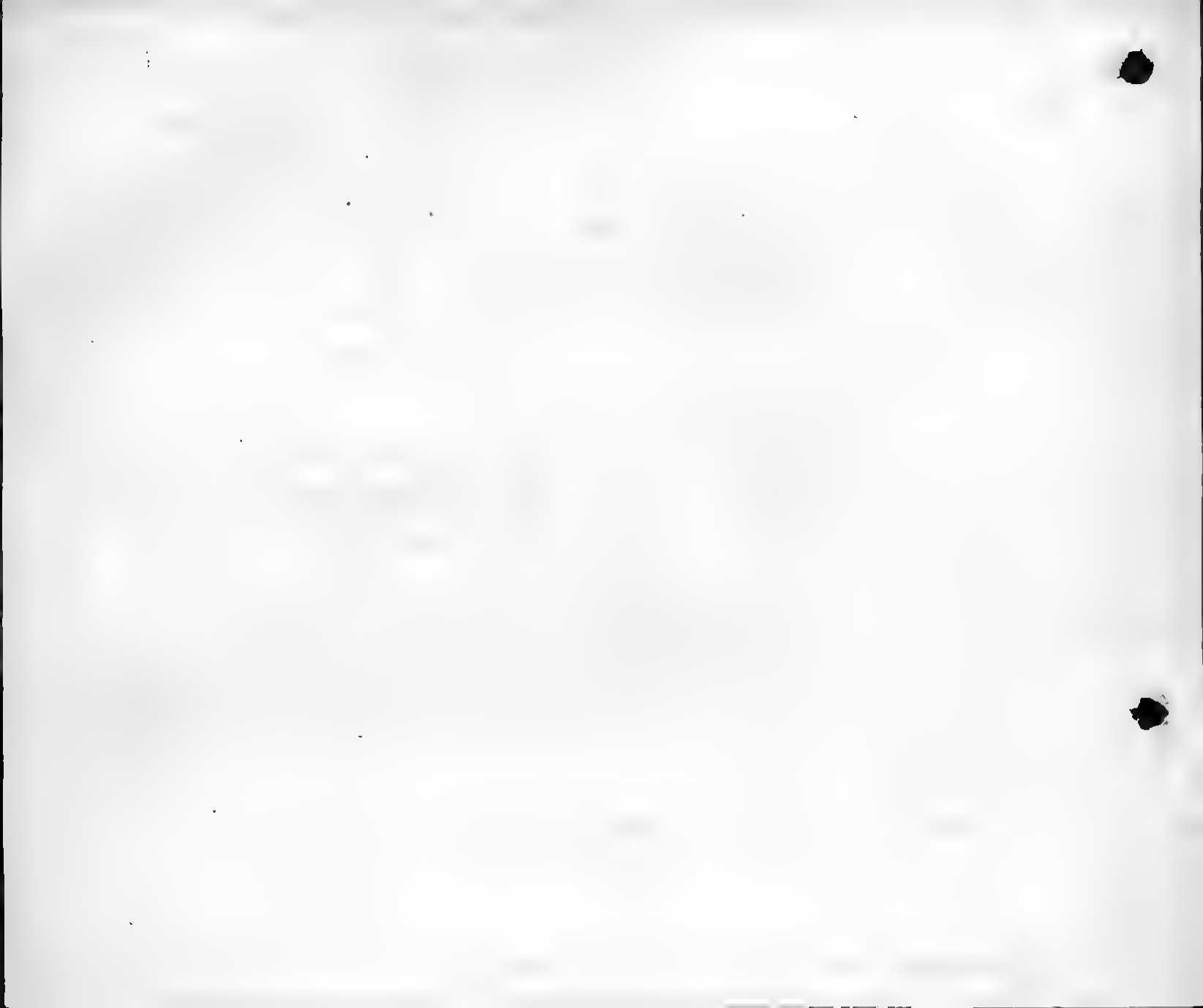
Items 13 & 14, telephone call Ulrich Funeral Home 4/18/61. cec

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3159 BAYBRIAR RD.</u>				d. STREET ADDRESS <u>13159 BAYBRIAR RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LOUISE</u>		First <u>LOUISE</u> Middle <u>KANE</u> Last <u>KANE</u>		4. DATE OF DEATH <u>APRIL</u> Month <u>17</u> Day <u>1961</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 22, 1976</u>	9. AGE (In years lost birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>— NEILL, William Henry</u>				14. MOTHER'S MAIDEN NAME <u>— ARNETT, Jane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>CHARLES H. RANDALL 3159 BAYBRIAR RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertension</u> DUE TO (b) <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day - 2 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>march</u> , 19 <u>59</u> , to <u>April 17/61</u> , that I last saw the deceased alive on <u>April 17, 1961</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. H. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>107 N. Main St. Balto 22</u>			
PHYSICIAN'S NAME (Type) <u>G. H. Thomas</u>				DATE SIGNED <u>4/17/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-20-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULRICH FUNERAL HOME, DUNDALK, MD.</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR DATE <u>APR 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 of this certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3980

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03974

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. LENGTH OF STAY IN 1b 1yr 3 mos +			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anna Rose Karn				4. DATE OF DEATH Month Day Year April 28 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown George Karn				14. MOTHER'S MAIDEN NAME Unknown Mary Veltz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. -		17. INFORMANT Address RECORDS: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage							
DUE TO (b) Cerebral arteriosclerosis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Diabetes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/25 1961 , to 4/28 1961 , that (I) (we) last saw the deceased alive on 4/28 1961 , and that death occurred at 9:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Loretta Hsu				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/28/61	
22c. PHYSICIAN'S NAME (Type) Loretta Hsu M.D.				22d. ADDRESS Spring Grove State Hospital			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY Louisa PK Cem		23d. LOCATION (City, town, or county) (State) Balto 29 MD	
24. FUNERAL DIRECTOR'S SIGNATURE McCurley Funeral Home 130 E Fort Ave				25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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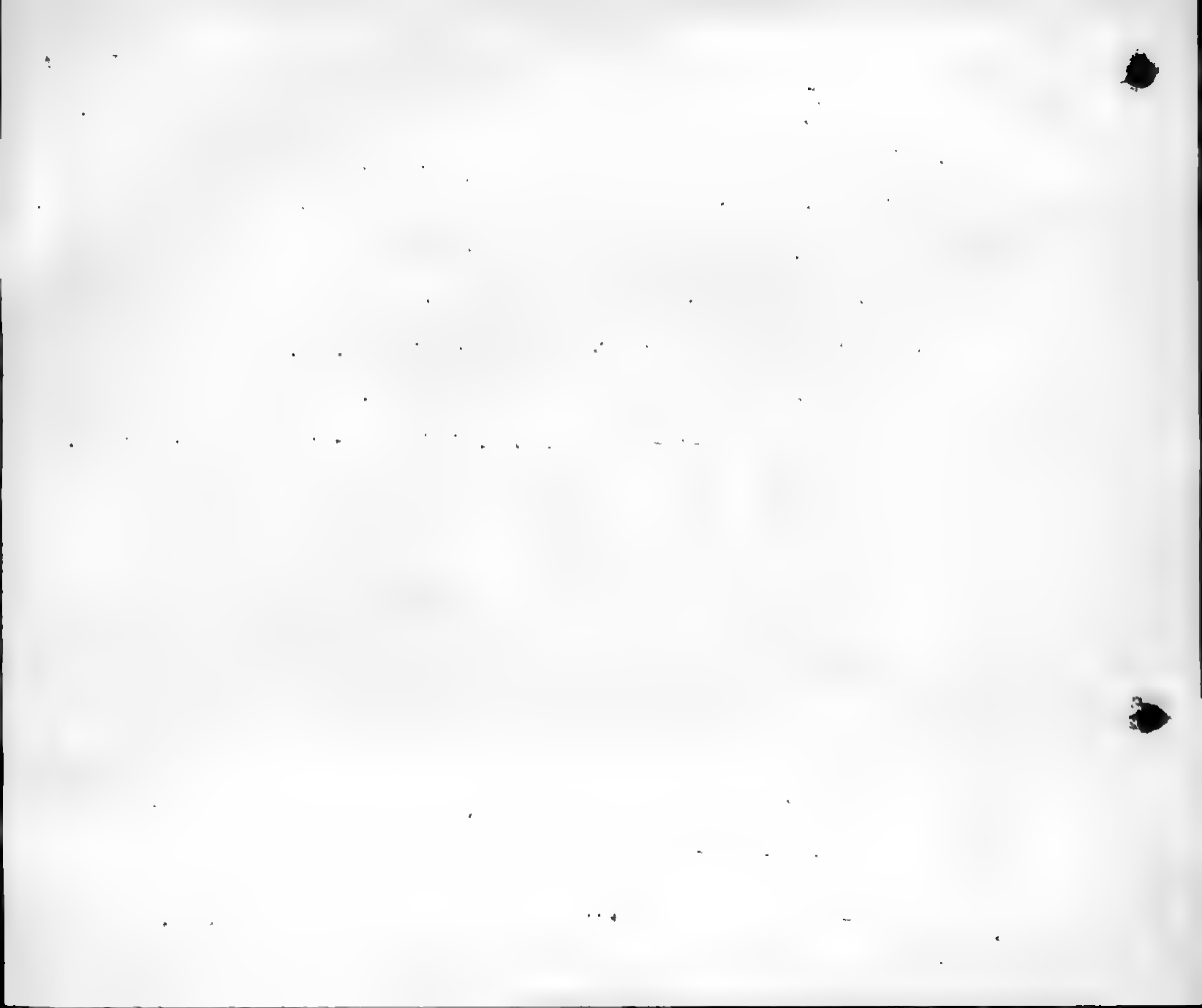
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MEDICAL CERTIFICATION



MEDICAL CERTIFICATION

V5 A15 (4)
15M 9/5B



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03976

Reg. Dist. No.

2082

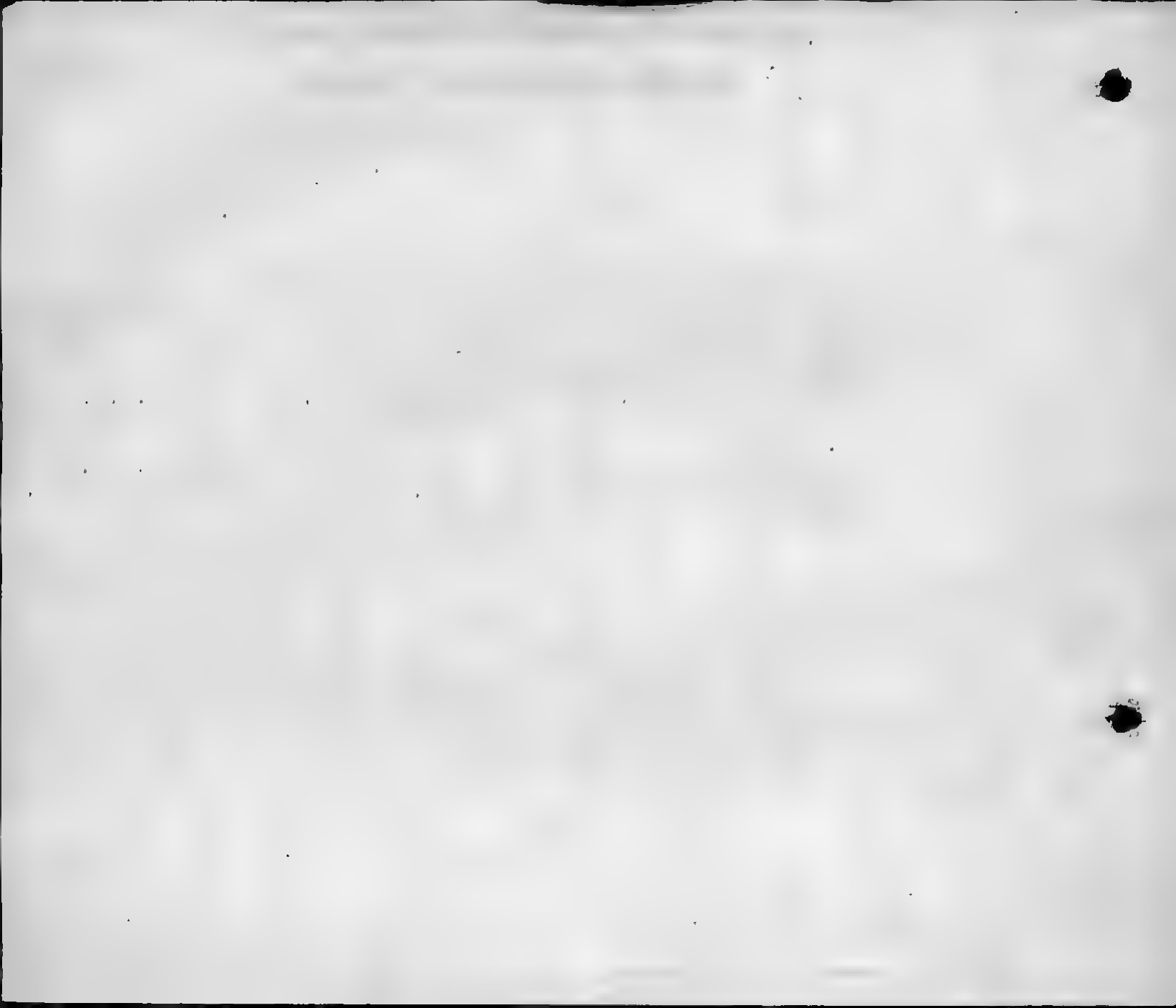
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY OR TOWN Rural Stevenson		LENGTH OF STAY (in this place) Lifetime		CITY OR TOWN Stevenson, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) Keller Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Harry (Middle) Hamilton (Last) Keller				(Month) April (Day) 21 (Year) 19 61			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 12, 1896	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		10b. KIND OF BUSINESS OR INDUSTRY Son Harry H. Keller		11. BIRTHPLACE (State or foreign country) Stevenson, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jackson E. Keller				14. MOTHER'S MAIDEN NAME Ida Merrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 216-05-9057		17. INFORMANT & ADDRESS Stevenson, Md. Mrs. Mary Ethel Keller, Keller Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Carcinoma prostate				INTERVAL BETWEEN ONSET AND DEATH 3 years			
ANTECEDENT CAUSE(S) DUE TO (B) metastasis to bone etc.				2 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr 28 , 19 58 , to Apr 21 , 19 61 , that I last saw the deceased alive on Apr 21 , 19 61 , and that death occurred at 9 P.M. , from the causes and on the date stated above.							
SIGNATURE John F. Williams		ADDRESS (Street, city, town, state) Linn Rd. Owings Mills, Md.		DATE SIGNED May 1, 1961			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 24, 1961		NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		LOCATION (City, town, or county) (State) Pikesville, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE William S. Kead		25. FUNERAL DIRECTOR'S SIGNATURE Frank J. Howell		ADDRESS 7200	
DATE Apr 25 '61							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the funeral home copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3983

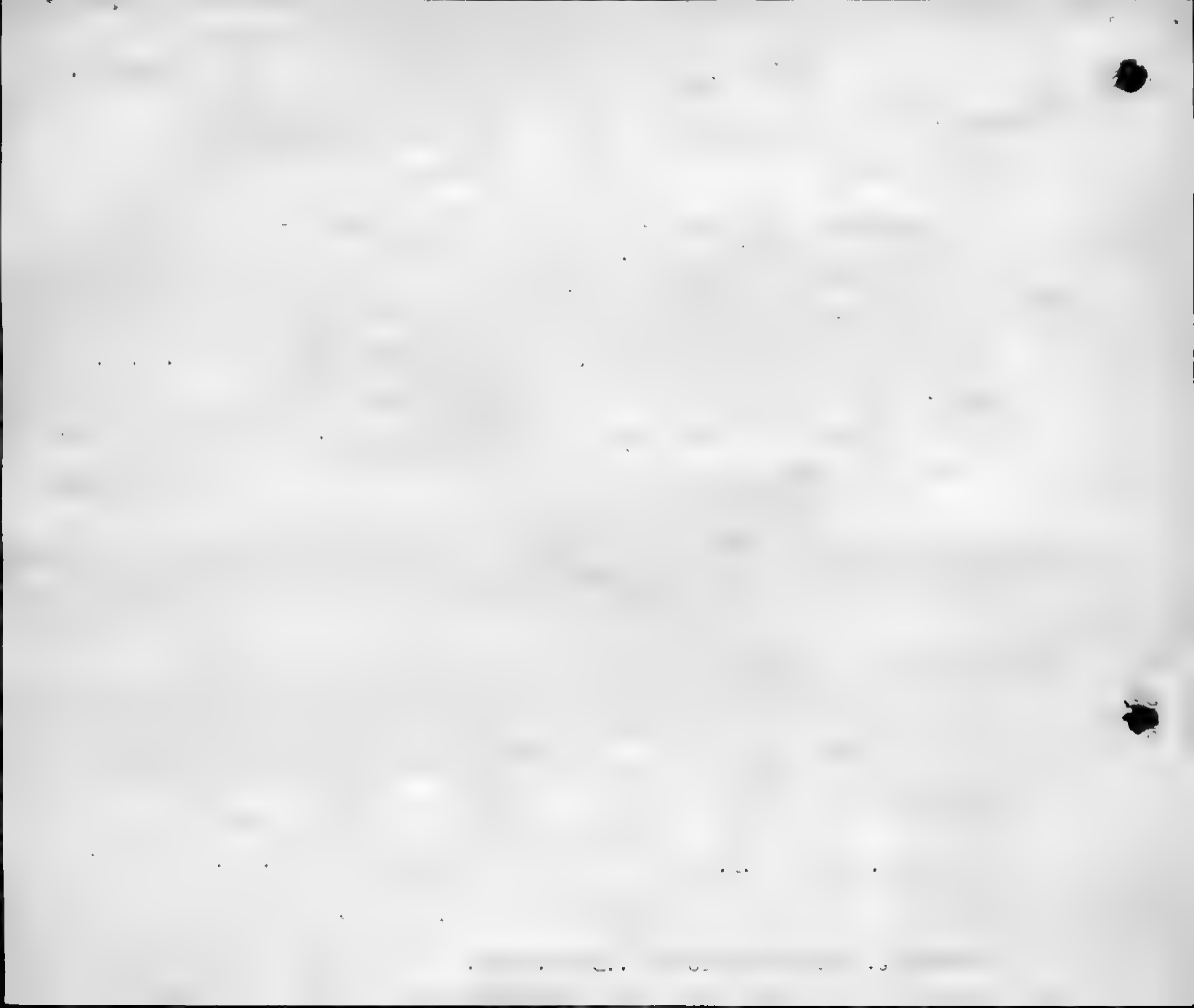
CERTIFICATE OF DEATH

03977

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 41 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore (18) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 545 East 23rd Street d. STREET ADDRESS 3711 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES W. KELLY		4. DATE OF DEATH Month Day Year April 27 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 11, 1930	
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 31	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John M. Kelly	
14. MOTHER'S MAIDEN NAME Bessie Byrne		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean	
16. SOCIAL SECURITY NO. 214-26-5905		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE a) BRONCHOPNEUMONIA IX XX XX ASPIRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XX XX ULCERATIVE COLITIS (c)		INTERVAL BETWEEN ONSET AND DEATH FEW HOURS 5 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from March 17, 1961 to April 27, 1961 that (we) last saw the deceased alive on April 27, 1961, and that death occurred at p.m., from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Crahan</i>		22b. DATE SIGNED 4/28/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		25a. REC'D BY REGISTRAR MAY 1 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		25c. ADDRESS 5305 Harford Rd., Balto. 14, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

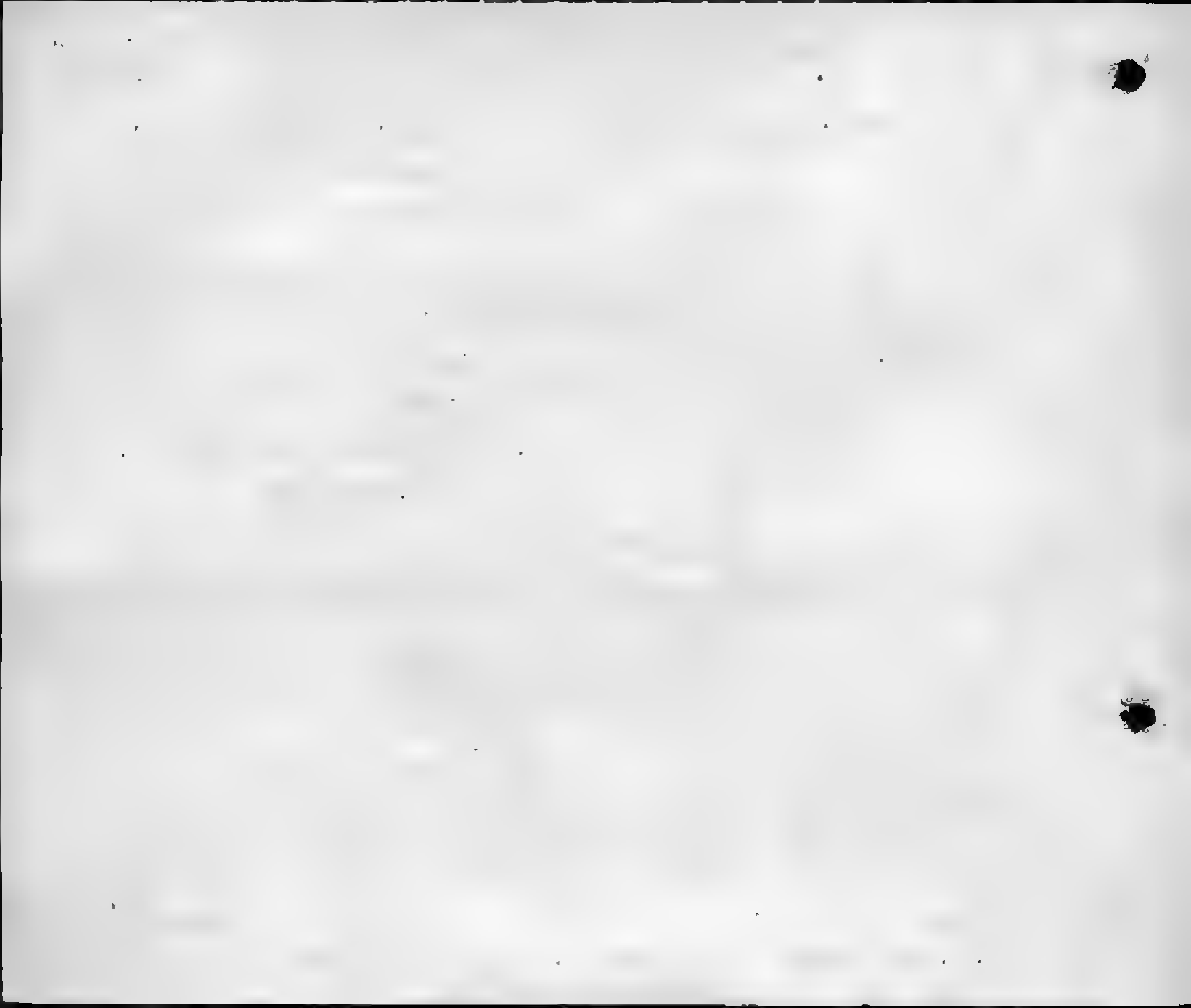
CERTIFICATE OF DEATH

03978

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Liberty Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills</u> d. STREET ADDRESS <u>Deer Park Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Patrick Joseph Kennedy</u> First Middle Last				4. DATE OF DEATH <u>April 7, 1961</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1893</u>			
9. AGE (In years last birthday) <u>68 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sun Cab Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>					
13. FATHER'S NAME <u>Thomas Kennedy</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>213-18-9050</u>					
17. INFORMANT <u>Mrs. Gladys Johnson Owings Mills, Md.</u>				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive Heart Failure</u> (b) <u>Chr. Valvular Heart Disease</u> (c) <u>Bronchial Asthma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 6, 1961</u> to <u>Apr 7, 1961</u> that (I) (we) last saw the deceased alive on <u>Apr 6, 1961</u> and that death occurred at <u> </u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Am. E. Martue</u>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME <u>Am. E. Martue</u>				22d. ADDRESS <u>Randallstown Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 10, 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Granite Cemetery</u>		23d. LOCATION (City, town or county) <u>Granite Md.</u> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>				25a. REC'D BY REGISTRAR <u>APR 12 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>				25c. ADDRESS <u>Reisterstown, Md.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

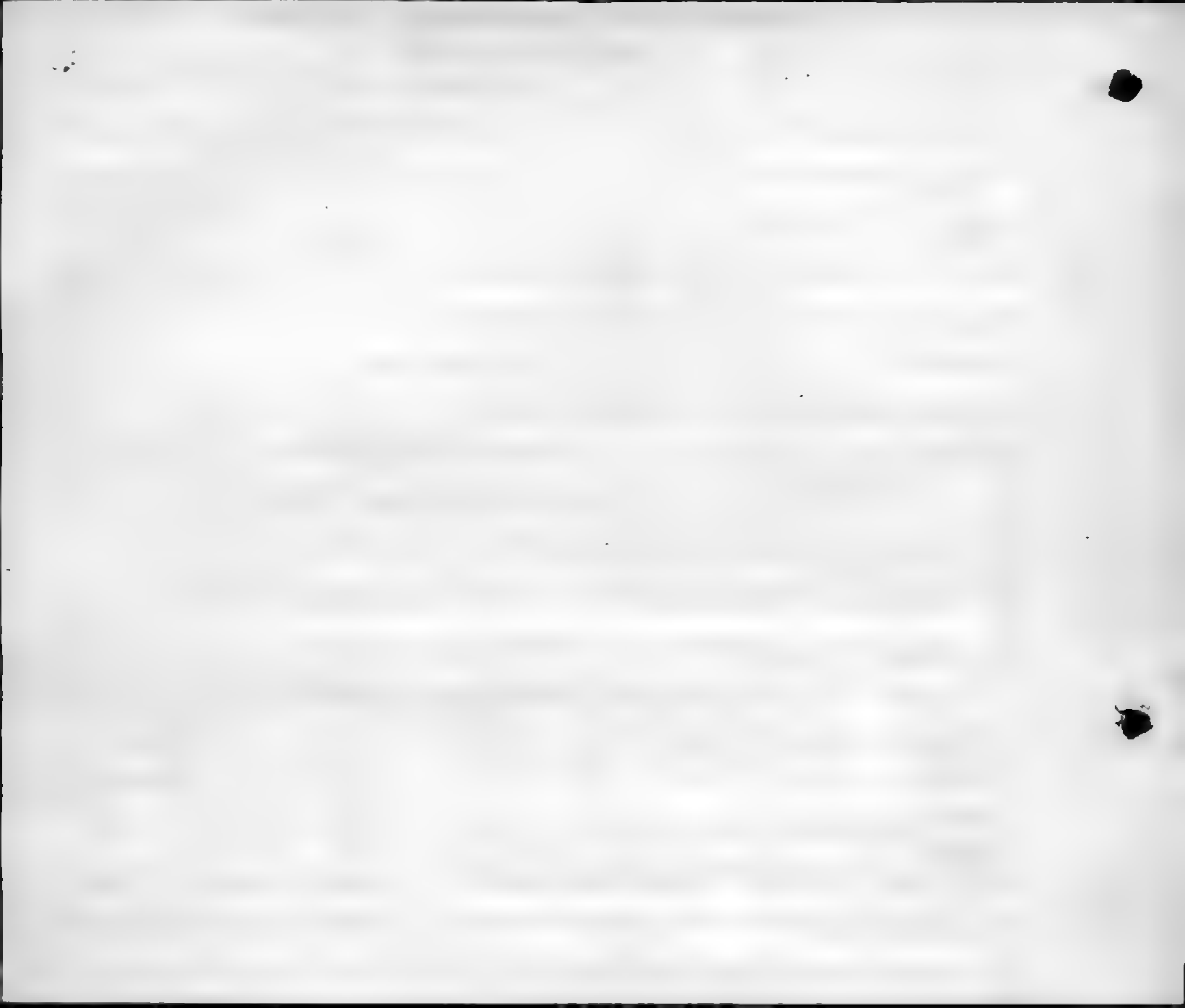
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2985

CERTIFICATE OF DEATH

Reg. Dist. No. 03979

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3016 Taylor Ave</u>		d. STREET ADDRESS <u>3016 Taylor Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>May</u> Last <u>Kirby</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>9</u> Days <u>9</u> Hours <u>1</u> Min <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ontario, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hiram Jones</u>		14. MOTHER'S MAIDEN NAME <u>Ida Medora Hannan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss Miriam T. Kirby</u>		Address <u>3016 Taylor Ave. #14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic CVD.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 yrs. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>57</u> , to <u>4/9</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/6/61</u> , 12 <u>00</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Grott</u> M.D.		ADDRESS (Street, city or town, state) <u>8100 Stanford Rd -</u> DATE SIGNED <u>4/10/61</u>	
PHYSICIAN'S NAME (Type) <u>H. A. GROTT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>4/11/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodmere Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Detroit Michigan</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Townson Inc.</u> ADDRESS <u>1050 York Rd. #4</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

Page 4

1
(M)
3986
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03980

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. LENGTH OF STAY IN 1b 17 years plus					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2441 E. Hoffman Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Koch				4. DATE OF DEATH Month April Day 12 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1879			
9. AGE 81 years 10 months 1 day		10. UNDER 1 YEAR Months 10 Days 1 Hours 1 Min. 1		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —					
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address —					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) —								INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —			
20f. (City or town) —				20g. (County) —		20h. (State) —			
21. I certify that (I) (this hospital) attended the deceased from March 10, 19 61 to April 12, 19 61 that (I) (we) last saw the deceased alive on April 12, 19 61 and that death occurred at 1:25 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar M.D.				22b. ADDRESS Spring Grove State Hospital Catonsville 28, Maryland					
22c. PHYSICIAN'S NAME (Type) Stella Wachslar M.D.				22d. ADDRESS Spring Grove State Hospital Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4 - 17 - 61		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			
23d. LOCATION (City, town, or county) Baltimore				23e. (State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St., Baltimore 2, Md.				25a. REC'D BY REGISTRAR DATE APR 18 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

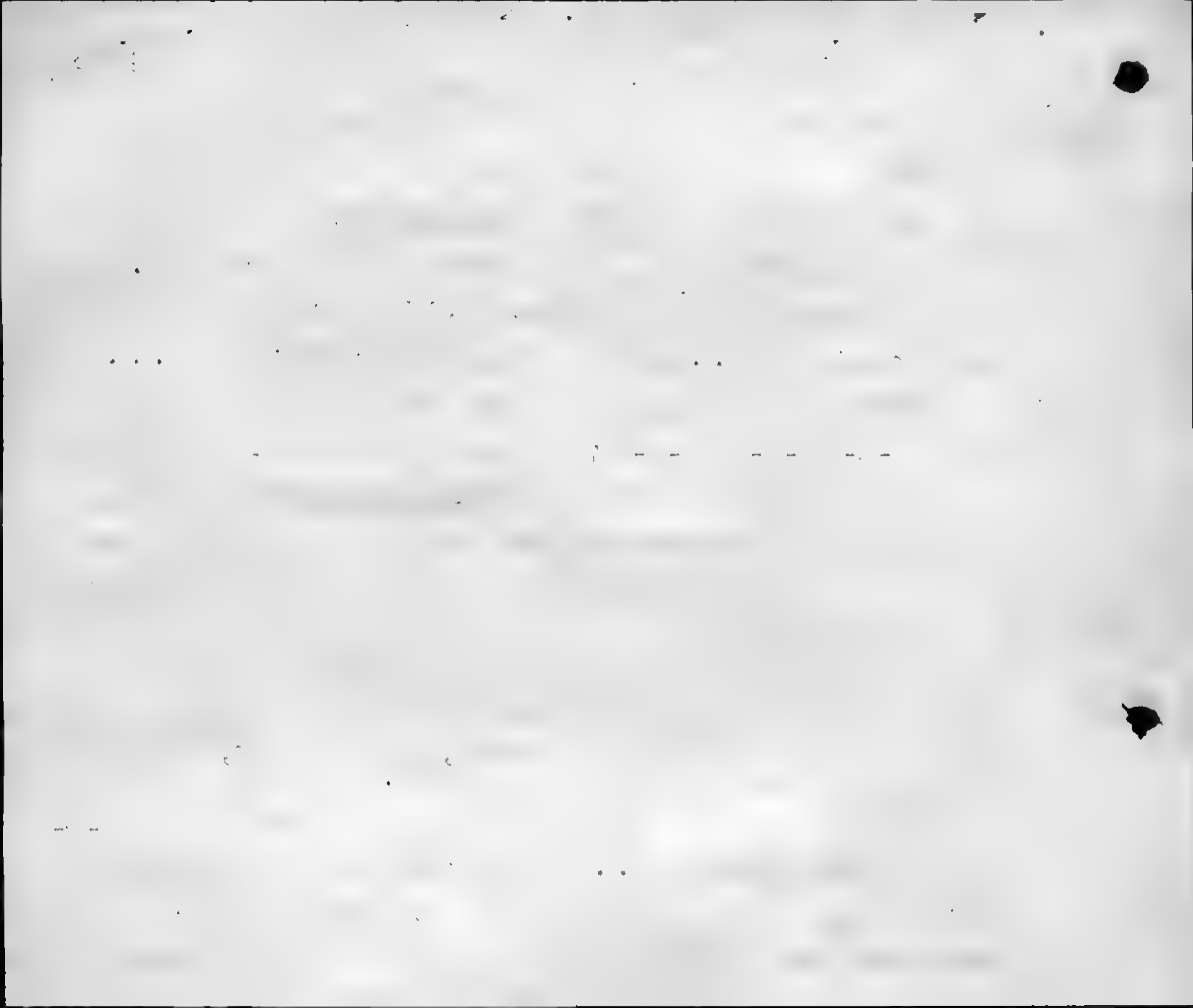


2987

Item 27b, Film 6200 5/12/64 - iwk

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03982**

2088

FOR STATE
HEALTH DEPT.

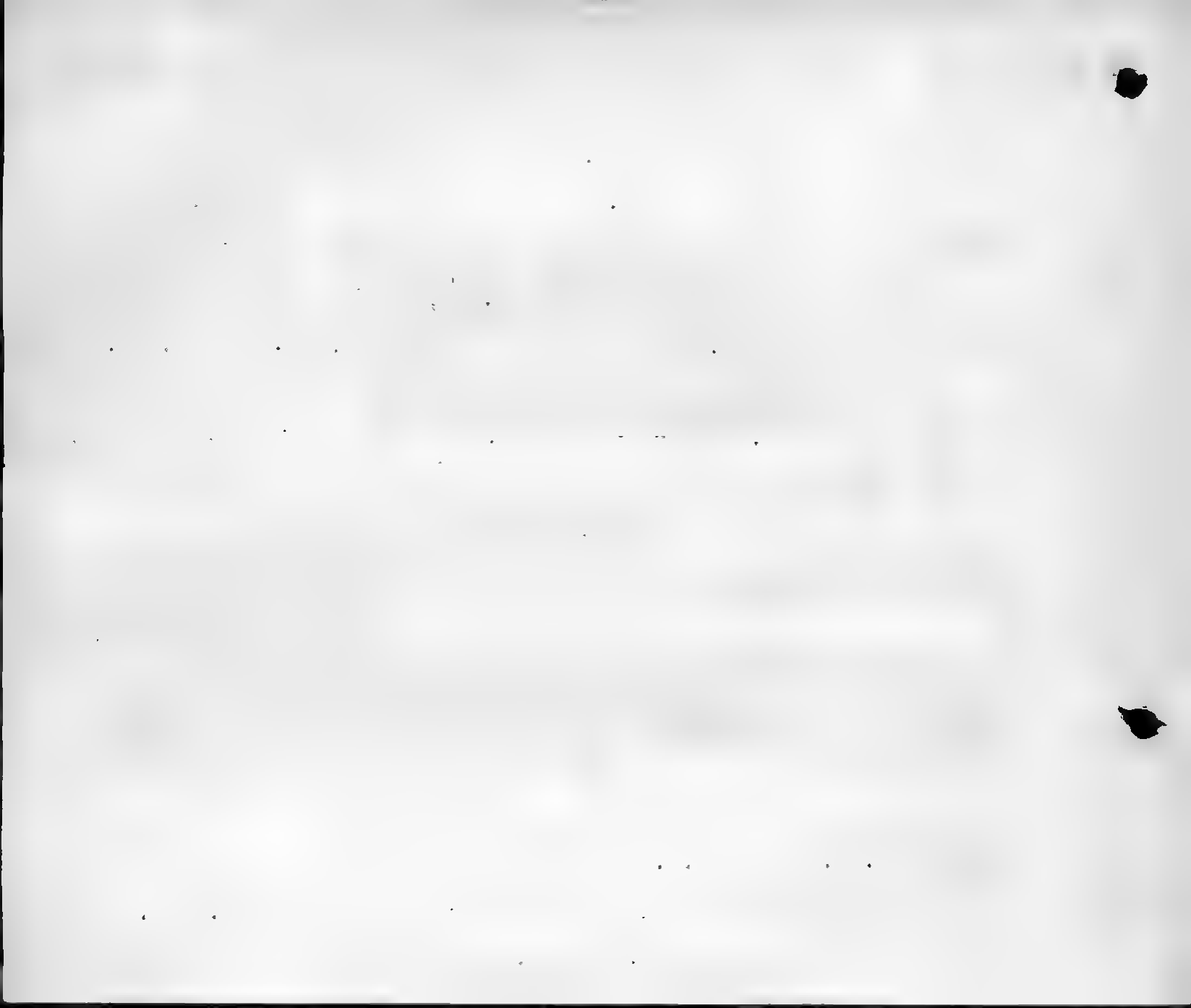
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

X

(I)

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 5 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 14 Old North Point Rd.				d. STREET ADDRESS 114 Old North Point Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Lbie Last Lbie				4. DATE OF DEATH Month April Day 19 Year 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1896		9. AGE (In years, less birth day) 54 yrs.	IF UNDER 1 YEAR: Months 1 Days 19 Hours 19 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lieut. S. U. S. Army		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Lbie				14. MOTHER'S MAIDEN NAME Mary Kuban			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army 1st.		16. SOCIAL SECURITY NO 213-28-7717		17. INFORMANT Address Mrs. Elena Mlynarski 53 Ontario St. Pitt Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-Disease							
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (b) Obesity							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-1961		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Proctorick Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOHN J. DUDA 7922 Wise Ave. 22, Md.				24a. REC'D BY REGISTRAR DATE APR 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	



2089

CERTIFICATE OF DEATH

Reg. Dist. No.

03983

1 PLACE OF DEATH a. COUNTY Baltimore				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1732 Burnham Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle MARIE Last Larson				4. DATE OF DEATH Month April Day 8 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1925	
9. AGE (In years last birthday) yrs 36		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Christopher		14. MOTHER'S MAIDEN NAME Catherine Kehoe		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT J.B. Larson		Address same as #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of Uterus with metastasis generalized DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyperthroid						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from 4-1 , 19 60 , to 4-8 , 19 61 , that I last saw the deceased alive on April 7 , 19 61 , and that death occurred at 8:30 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack C. Collins M.D.				ADDRESS (Street, city or town, state) 2 Kinship Rd. DATE SIGNED 4-8-61			
PHYSICIAN'S NAME (Type) Jack C. Collins M.D.				22a. BUHAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 4/12/61				22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery			
22d. LOCATION (City, town, or county) Kingston, Pennsylvania				23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.			
24a. REC'D BY REGISTRAR 4-10-61				24b. REGISTRAR'S SIGNATURE William E. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

L CERTIFICATION

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
4/15/61

24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.
APR 15 1961

25B. NAME OF REGISTRAR
Arthur J. Williams

25C. FUNERAL DIRECTOR ADDRESS
W. B. Wilbert 1300 Eutaw Pl. 17

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g. heart failure, asphyxia, etc. It means the disease injury or complication which caused death)		CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) hypertensive Cerebro Vasculer disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4/5/61 2 years
19A. DATE OF OPERATION 4/12		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 44		
20. I certify that (I) (this hospital) attended the deceased from 4/12 19 61 to 4/10 19 61 and that in (my) (our) opinion death occurred at 3:55 m., from the causes and on the date stated above.				
23A. SIGNATURE Eliot J. Johnson ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS 3432 Baltimore 29, Md		23C. DATE SIGNED 4/13/61

1. NAME OF DECEASED (Type or Print) Sophia A. Laur		2. DATE OF DEATH April 12, 1961	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore County - 4408 Leeds Ave. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore - 29		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 29 C. CITY OR TOWN Baltimore City (If outside city limits, write RURAL and give township) D. STREET ADDRESS 4408 Leeds Ave. (If rural, give location)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 26, 1884
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (in years last birthday) 77
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oswald Floether		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 215-07-6906	
17. INFORMANT Helen Laur--4408 Leeds Ave.		ADDRESS	

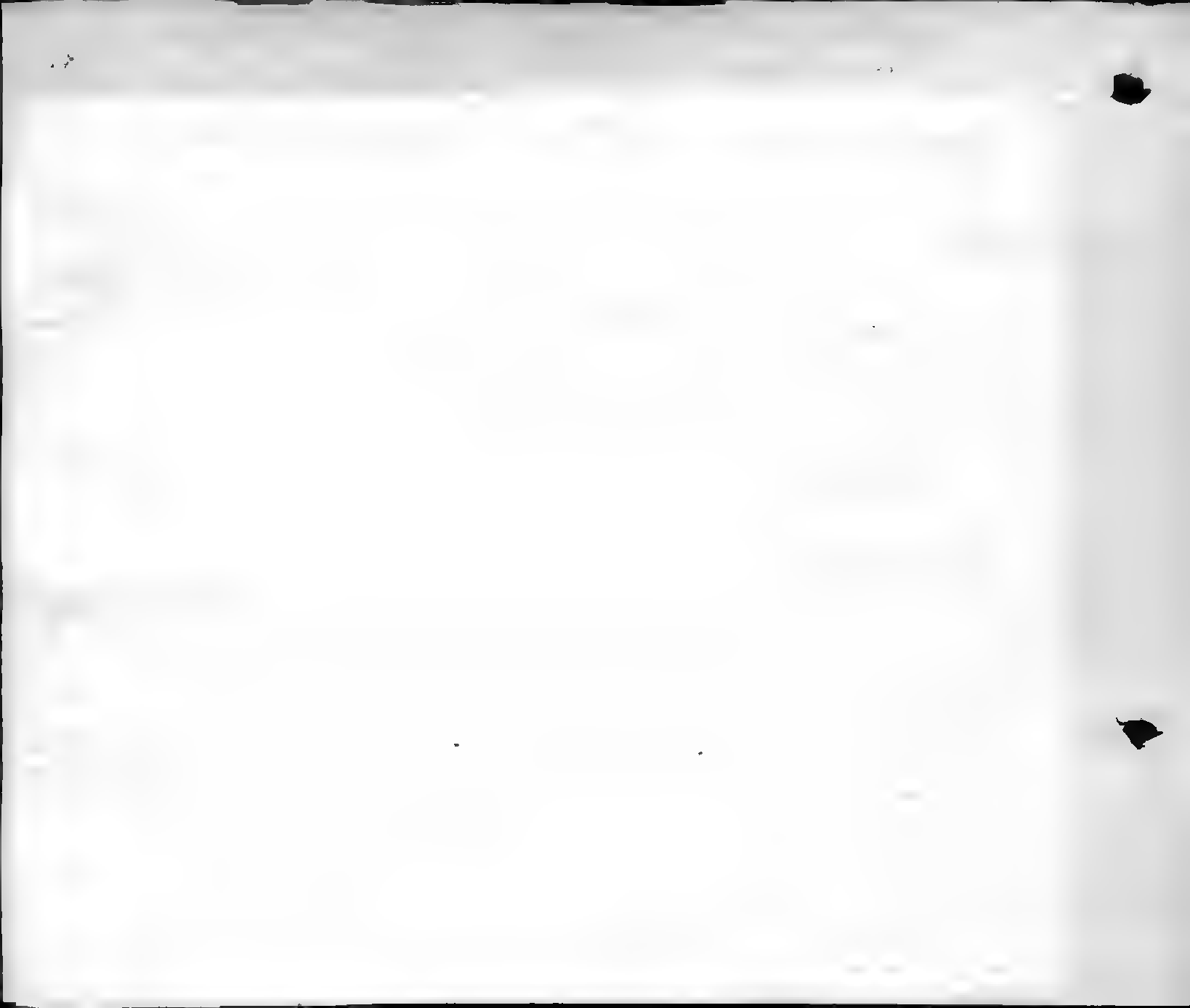
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03984

2020

1
M

VR A15 (4)
15M 9/60



3391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03985

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		c. LENGTH OF STAY IN lb <u>10yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		d. STREET ADDRESS <u>Hess Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hess Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hesse JAMES Leedy</u>				4. DATE OF DEATH Month Day Year <u>APR 5 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29 1906</u>	9. AGE (In years, last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Wytheville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence P. Leedy</u>				14. MOTHER'S MAIDEN NAME <u>Florence Cline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>312-32-0447</u>		17. INFORMANT Address <u>Mrs. Laura Leedy, Monkton, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed skull caused by shot</u> DUE TO (b) <u>gun blast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Shot through chest with a 12 gauge shotgun.</u>							
20c. TIME OF INJURY Month, Day, Year <u>11:15 p.m. 4/5 1961</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>MONKTON BALTO. MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/6/61</u>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 8 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Phoenix, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>APR 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

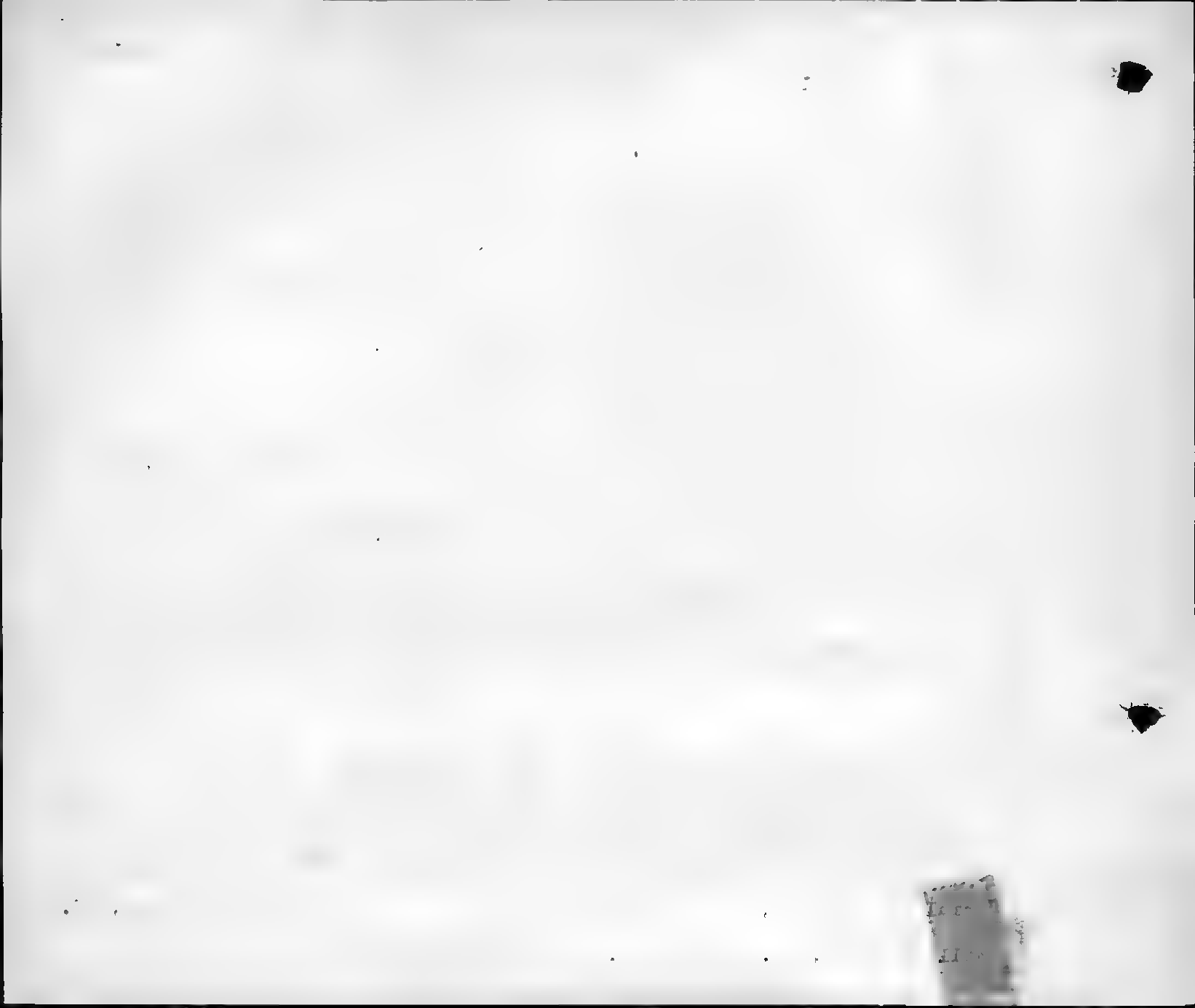
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3992

03986

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WOODLAWN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>COCKEYSVILLE</u>		c. LENGTH OF STAY IN 1b <u>11 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MASONIC HOME</u>		e. STREET ADDRESS <u>6408 GILMORE AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH YOUNG LEIDNER</u>		4. DATE OF DEATH Month Day Year <u>APRIL 18 1961</u>	
5. SEX <u>FF</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1870</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOLSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCOTLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM PATTERSON STRATTON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH YOUNG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Frank L. Smith Jr.</u> Address <u>Cockeysville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio</u> <u>422.1</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Vascular Disease</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-2</u> 1950, to <u>4-18</u> 1961, that (I) (we) last saw the deceased alive on <u>4-17</u> 1961, and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Walter T. Kees</u>		22b. DATE SIGNED <u>4/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>		22d. ADDRESS <u>COCKEYSVILLE, MD</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 21, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	
25a. REC'D BY REGISTRAR <u>APR 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2093

CERTIFICATE OF DEATH

Reg. Dist. No. 03987

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS Box 307	
3. NAME OF DECEASED (Type or print) First Mildred Middle L Last LEISTER		4. DATE OF DEATH Month APRIL Day 2 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 7 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER ON FARM		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CARROLL CO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WENTON LEISTER		14. MOTHER'S MAIDEN NAME SARA A. RECHSLEIR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-36-4120	
17. INFORMANT Miss Edna L. Leister, Finksburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF MESENTERIC CYST DUE TO 158X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-15 , 19 61 , to 4-2 , 19 61 , that I last saw the deceased alive on 4-1 , 19 61 , and that death occurred at 6:20 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton B. Kress M.D.			
PHYSICIAN'S NAME (Type) Milton B. Kress			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Buried		4/5/61	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Leiston Cemetery, Rural, Finksburg, Md.		Finksburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Meyer, Jr., Westminster, Md.		24a. REC'D BY REGISTRAR APR 6 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE William S. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03988

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)

Phoenix

c. LENGTH OF STAY IN 1b

Life

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Phoenix

d. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Jarrettsville Pike, Phoenix, Md

Jarrettsville Pike, Phoenix

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Albert

Henry Lins

4. DATE OF DEATH

Month

Day

Year

4

20

19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-6-1877

9. AGE (In years last birthday)

83 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Veterinarian

10b. KIND OF BUSINESS OR INDUSTRY

Doctor

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Christian Lins

14. MOTHER'S MAIDEN NAME

Margareta Daneker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

Address Box 32

Mrs. W. Leroy Conklin Phoenix, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary Occlusion
Myocardial Regeneration

Sudden

3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles J. Donnell

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4/20/61

EXAMINER'S NAME (Type)

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-22-61

22c. NAME OF CEMETERY OR CREMATORY

Jacksonville Reform

22d. LOCATION (City, town, or country)

Phoenix Maryland

23. FUNERAL DIRECTOR

Brooks Funeral Service Towson 4, Md

24a. REC'D BY REGISTRAR

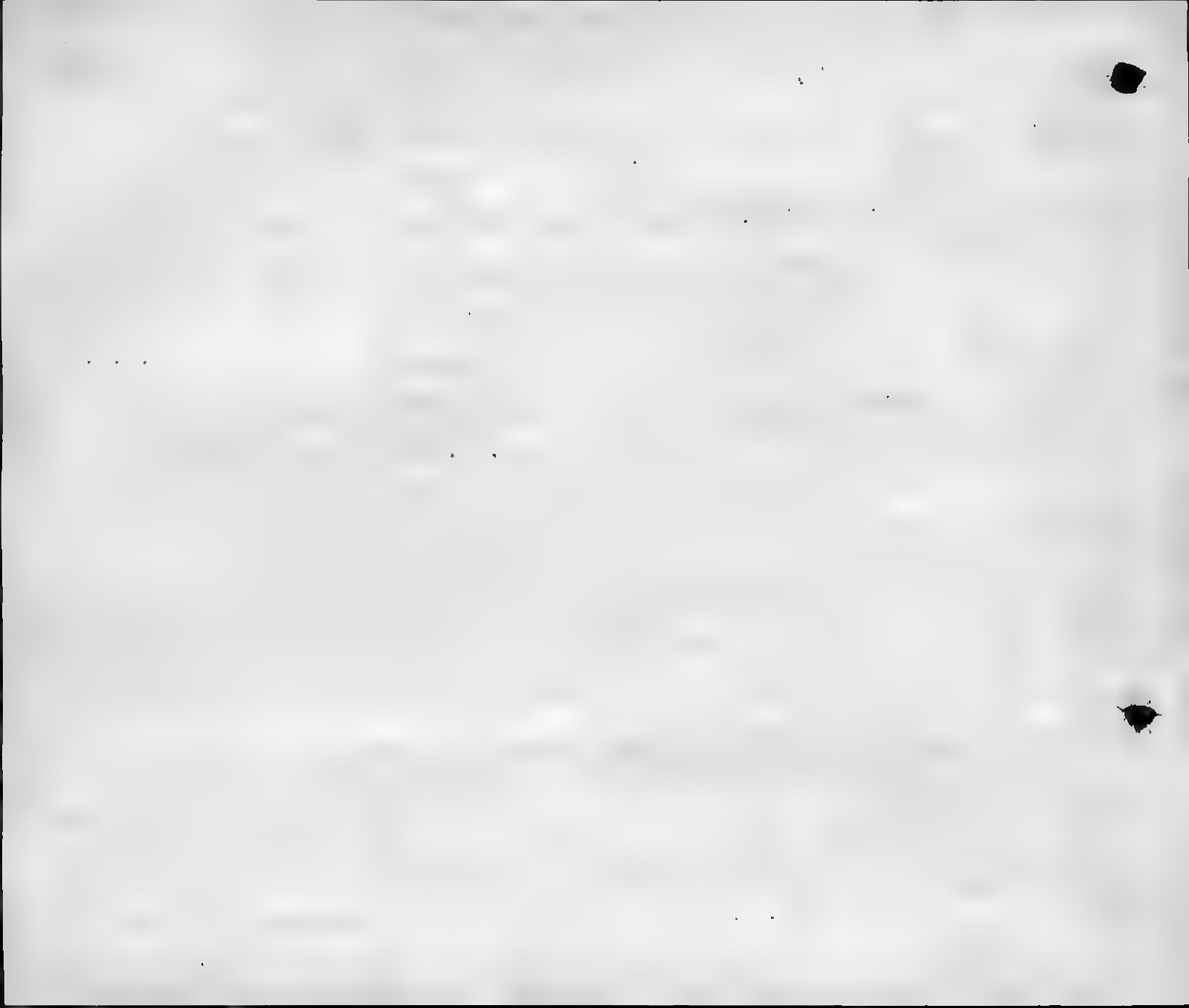
APR 24 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

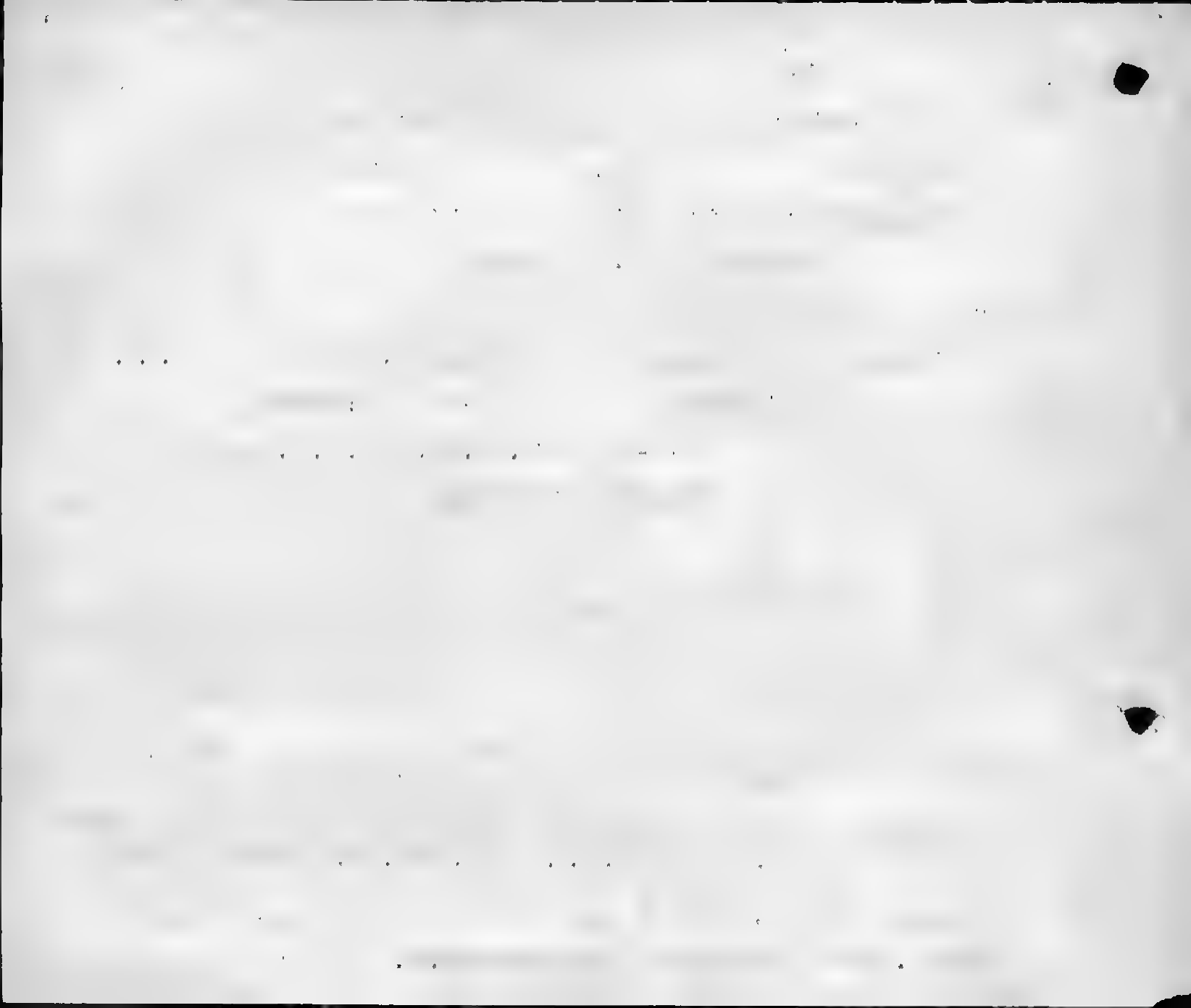
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03989

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN b. 4 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 4102 Audrey Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STANLEY A. LISIEWSKI		4. DATE OF DEATH APRIL 20TH 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/7/15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		9. AGE (in years last birthday) 46 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alexander Lisiewski	
14. MOTHER'S MAIDEN NAME Rose MN: Makovioz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-09-0544	
17. INFORMANT Clin. Rec. VAM, Balto. Md. Ft. Howard Division		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that W (this hospital) attended the deceased from April 16, 1961 to April 20, 1961 that W (we) last saw the deceased alive on April 20, 1961 , and that death occurred at 5:15 PM from the causes and on the date stated above					
22a. SIGNATURE <i>George C. McElfatrick</i>		22b. DATE SIGNED 4/20/61		22c. PHYSICIAN'S NAME (Type) GEORGE C. McELFATRICK, M.D.	
22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 24, 1961	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland		23e. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce		24b. ADDRESS 4001 Governor Ritchie Hwy, Balto. Md.		25. REGISTRAR'S SIGNATURE Arthur S. Kincaid	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



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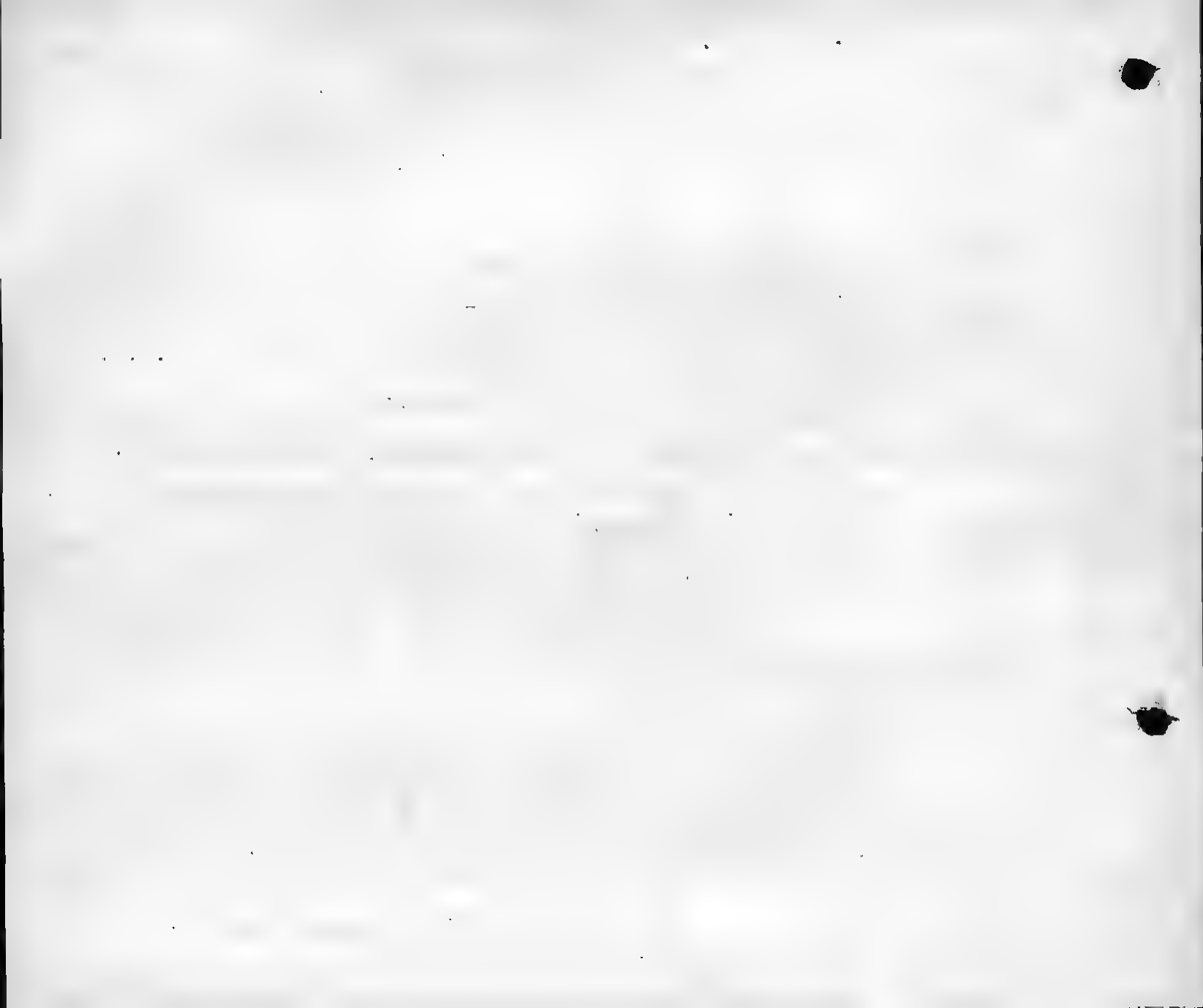
VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03990

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister			
c. LENGTH OF STAY IN 1b 3 yrs.				d. STREET ADDRESS Uniontown Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dora Middle May Last Lloyd				4. DATE OF DEATH Month 4 Day 25 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-13-1874	
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frederick Bremker				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO -		17. INFORMANT Helen A. Sines Uniontown Rd Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Certain sclerotic Cardio Vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1959 4/25 to 1961 4/25 , that (I) (we) last saw the deceased alive on 4/25 1961, and that death occurred at 7 PM , from the causes and on the date stated above							
22a. SIGNATURE A. M. France				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4/27/61	
22c. PHYSICIAN'S NAME (Type) A. M. FRANCE				22d. ADDRESS Parkton, Md			
23a. BURIAL, CREMATION REMOVAL (Specify) Buried		23b. DATE THEREOF 4-28-61		23c. NAME OF CEMETERY OR CREMATORY Blackrock Cemetery		23d. LOCATION (City, town, or county) (State) Butler Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md				25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kinas	





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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3998

Items 8 & 9 film 6203 4/27/61 ink

03992

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1718 Hillyard Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>7</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>1718 Hillyard Road</u>			
3. NAME OF DECEASED (Type or print) <u>Abner Lee Lockett</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-11878</u> 1876 <u>84</u> yrs.	9. AGE (if years last birthday) <u>84</u> yrs.	10. IF UNDER 24 HRS. Months <u>8</u> Days <u>4</u> Hours <u>11</u> Min. <u>15</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <u>Georgia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Rubin Winfrey Lockett</u>		14. MOTHER'S MAIDEN NAME <u>Camilla Park</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>257016603 Andrew Lockett</u>			
16. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis & Heart Disease</u> (b) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from June 10, 1960 to April 24, 1961, that (I) (we) last saw the deceased alive on 4/24 1961, and that death occurred at 3 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Nathan Janney</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/24/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>NATHAN JANNEY</u>		22d. ADDRESS <u>7101 Harford Rd.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4-26-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	25a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>	25b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>			

VR A15 (4)
15M 9/60



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 301. Winston Ave	
3. NAME OF DECEASED (Type or print) First GLADYS Middle MAY Last LONG		4. DATE OF DEATH Month 4 Day 16 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1895
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HARTFORD Co. MD	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME ROBERT J. BEARD		14. MOTHER'S MAIDEN NAME IDA MAY MYERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-13-1847	
17. INFORMANT Miss A. BEARD		Address 305 Winston Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, FAR ADVANCED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c) 002X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATOID ARTHRITIS, ACUTE BRAIN SYNDROME 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-27 , 19 61 , to 4-16 , 19 61 , that I last saw the deceased alive on 4-15 , 19 61 , and that death occurred at 5 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eudowood Sanatorium DATE SIGNED 4-16-61 ACTUAL SIGNATURE William B. Kress M.D. Eudowood Sanatorium PHYSICIAN'S NAME (Type) William B. Kress			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-61	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd.	
24a. REC'D BY REGISTRAR DATE APR 18 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kress	



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VR A15 (4)
15M 9/59

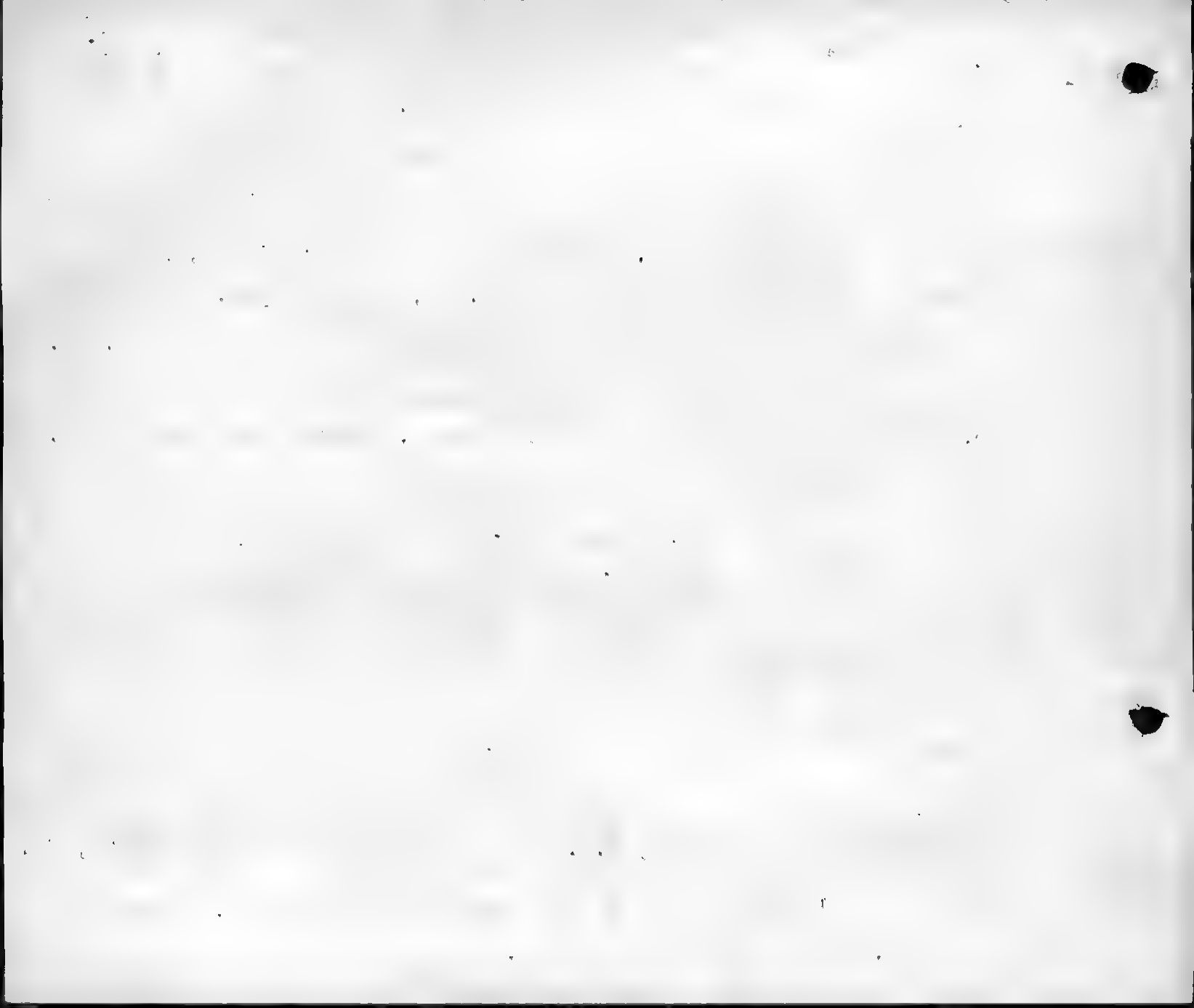
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03994

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1201 Francis Avenue		d. STREET ADDRESS 1201 Francis Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillie Middle M. Last Lowman		4. DATE OF DEATH Month April Day 10 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Ring		14. MOTHER'S MAIDEN NAME Lydia Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Clarence E. Lowman		Address 1201 Francis Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cholesterol DUE TO (c) Arterial Hypertension		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/12/61 to 4/10/61 , that (I) (we) last saw the deceased alive on 4/11/61 and that death occurred at 2 M, from the causes and on the date stated above			
22a. SIGNATURE Bruce Brumbaugh, M.D.		22b. ADDRESS 5609 Main Street Elkridge 27, Md.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR Apr 12 '61	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Clarence E. Lowman	



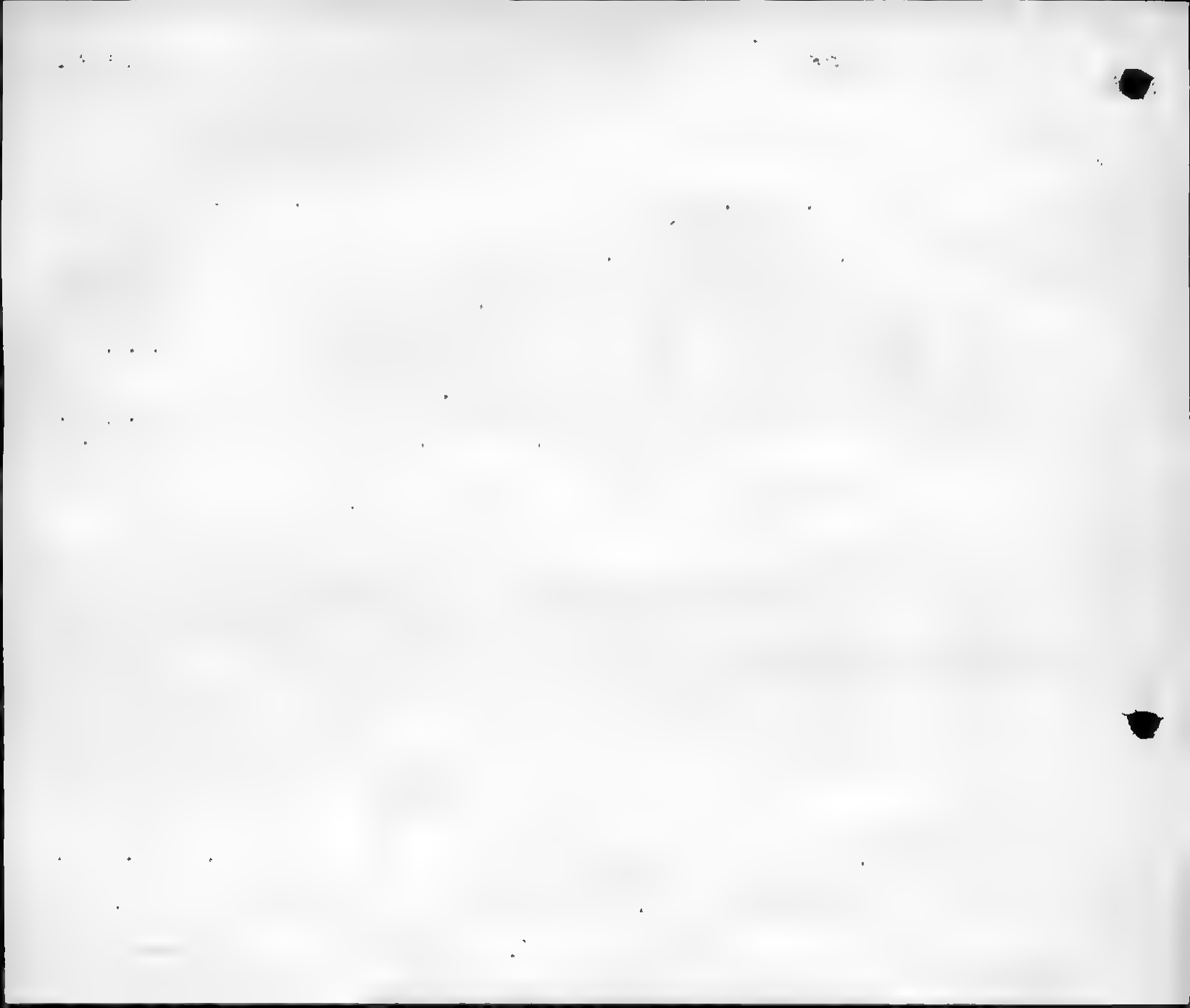
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VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03995

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Pikesville		c. LENGTH OF STAY IN 1b 5 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 McHenry Rd. Balto. 8		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural- Pikesville	
		d. STREET ADDRESS 1 613 McHenry Rd. Balto.8	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Mrs. Amanda Middle B. Last Macken		4. DATE OF DEATH Month April Day 3 Year 19 61	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 31, 1876
9 AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done) 10b KIND OF BUSINESS OR INDUSTRY Housewife None		11 BIRTHPLACE (State or foreign country) Germany	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Beyer		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Walter H. Macken, 7233 Windsor Mill Rd.		Address Balto.7, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 450.0 DUE TO Information 7 age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Asthma (Severe Allergy)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 1940 to April 3, 1961 , that (I) (we) last saw the deceased alive on April 3, 1961 , and that death occurred at 6 M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Thomas F. Abbott		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas Abbott		22d. ADDRESS 4509 Liberty Heights Ave. Balto.7, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-1961	
23c NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d LOCATION (City, town, or county) (State) Randallstown, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Loring Beyer		25a REC'D BY REGISTRAR DATE APR 7 '61	
ADDRESS 8728 Liberty Rd. Randallstown, Md.		25b REGISTRAR'S SIGNATURE Arthur S. Kane	



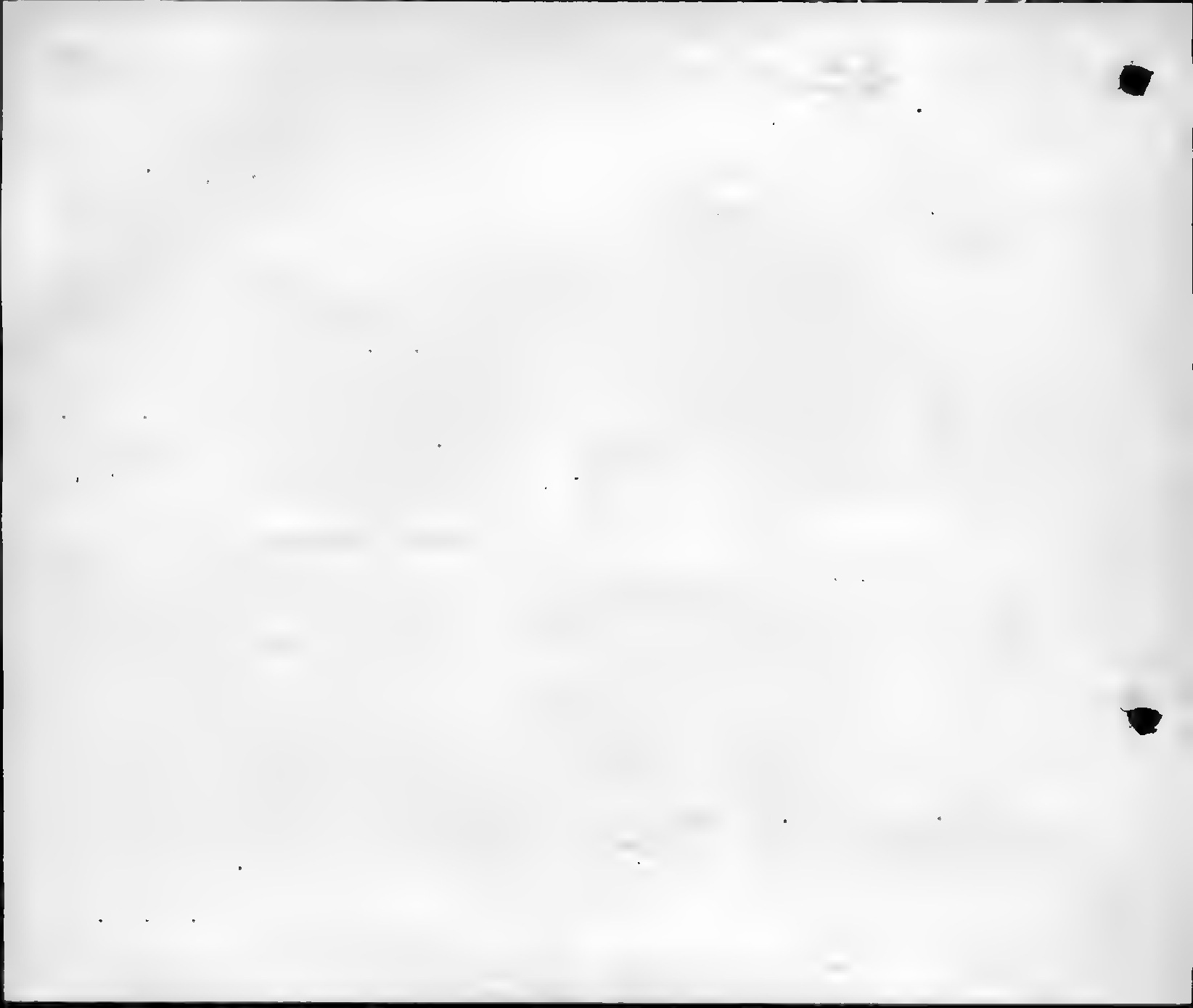
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03996

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville Balto. Co.</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8426 Loch Raven Blvd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville Balto. Co. Md.</u> d. STREET ADDRESS <u>8426 Loch Raven Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ettie</u> First <u>M</u> Middle <u>Maenner</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1894</u>
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min <u>7</u>	IF UNDER 24 HRS Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Brockmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brockmeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>218-02-9630</u>	
17. INFORMANT <u>Mr John B. Maenner</u>		Address <u>Balto. Md.</u> <u>4531 Northwood Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1</u> DUE TO <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Eleophysema - bronchiectasis</u> DUE TO <u>Hypertensive cardiovascular disease</u> (c) <u>Intermittent</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1961</u> to <u>4-5 1961</u> , that (I) (we) lost the deceased on <u>4-5 1961</u> and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Richard R. Rigler</u>		22b. DATE SIGNED <u>4-5 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rigler</u>		22d. ADDRESS <u>1 West Overlea Ave.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-10-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Joseph Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fullerton Balto. Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>	
ADDRESS <u>7461 Belair Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Robert L. Fries</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
4003 03997									
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY Da.							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				d. STREET ADDRESS	
3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		1732 Claridon Rd		1732 Claridon Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. NAME OF DECEASED (Type or print)		First Middle Last Mary Markelonis		4. DATE OF DEATH		Month Day Year April 11, 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18a. IMMEDIATE CAUSE (a)		18b. DUE TO (b)		18c. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
4-13A		Acute cardiac failure		Hypertensive cardio vascular disease		Generalized Arterio sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		25. DATE		26. REGISTRAR'S SIGNATURE	
Chris W. Fackelbusch		APR 17 '61		Arthur S. Kline					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

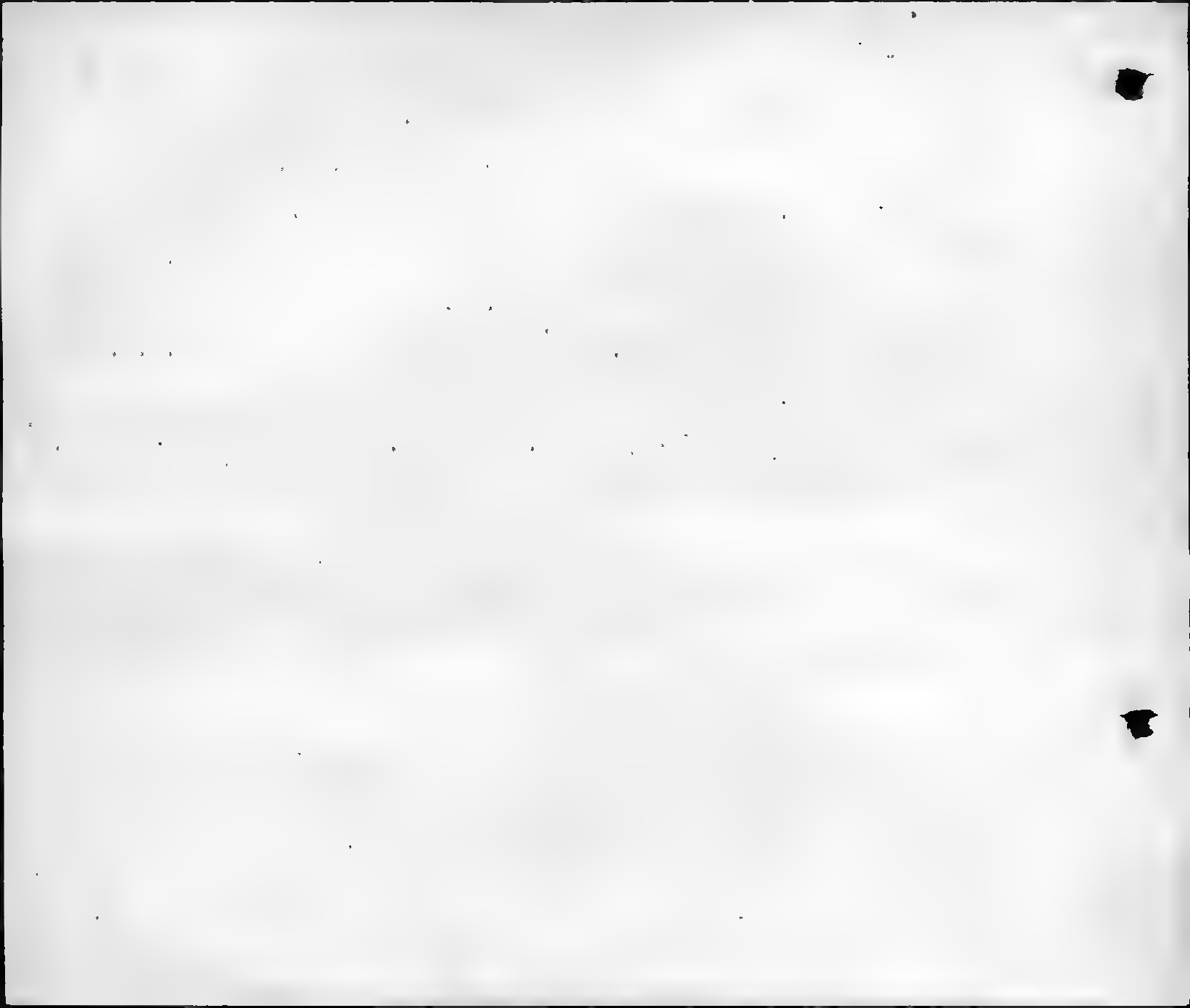
4004
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03998

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lutherville				c. LENGTH OF STAY IN 1b 8 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Lincoln Ave. Lutherville				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.			
f. STREET ADDRESS 211 Lincoln Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Edwin Last Martin				4. DATE OF DEATH Month April Day 15 Year 61			
5. SEX Male	6. COLOR OR RACE Color	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1883		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Baltic Transit Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Martin				14. MOTHER'S MAIDEN NAME MARY Fitch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-1523		17. INFORMANT Mr. Joseph W. Martin, 211 Lincoln Ave.		18. Lutherville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 2 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1960 to APR 15, 1961 , that (I) (we) last saw the deceased alive on APR 11, 1961 and that death occurred at 11 M, from the causes and on the date stated above.							
22a. SIGNATURE William A. Pillsbury M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/17/61	
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury				22d. ADDRESS 2060 York Rd. Timonium Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.				25a. REC'D BY REGISTRAR APR 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

I

1 M



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

(M)

X

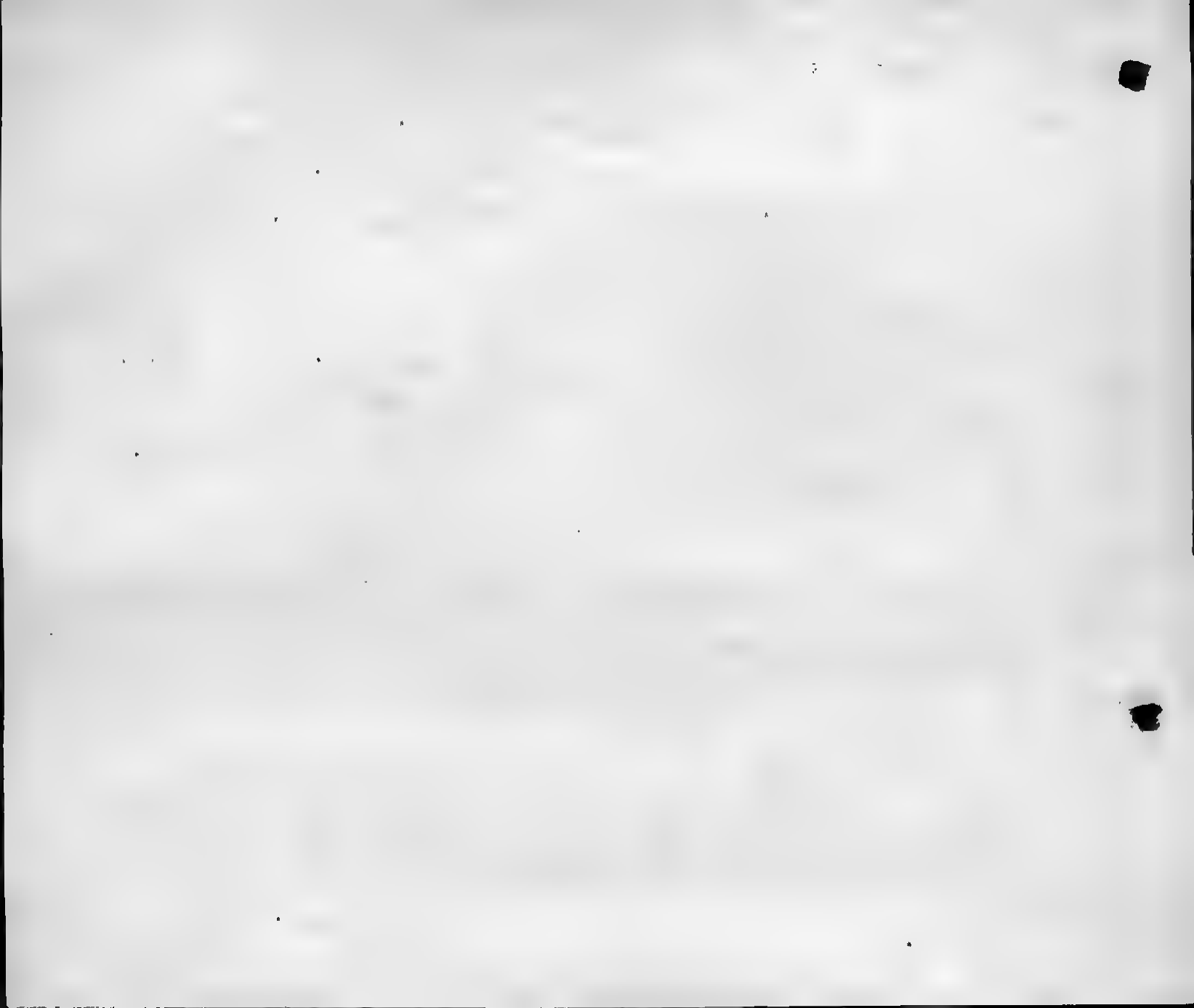
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VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03999

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co/</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>629 Orpington Rd. Catonsville</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Baltimore Co. Catonsville</u> d. STREET ADDRESS <u>629 Orpington Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>IRIS ANTHONY MASTER</u>		4. DATE OF DEATH <u>April 10 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS last birthday) <u>77</u> yrs. Months Days Hours Min.	
13. FATHER'S NAME <u>Jonathan Anthony</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Iatsen</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Barbara Iatsen</u> Address <u>629 Orpington Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO (b) <u>Coronary vascular disease</u> DUE TO (c) <u>Peripneumonic pneumonia (Pneumococcus agalactiae)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. E. S. M. KLEINER M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lakeside M E Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Kent Co. Delaware</u>	
23. FUNERAL DIRECTOR <u>John M. Weber Jr.</u>		24a. REC'D BY REGISTRAR <u>APR 13 '61</u>	
ADDRESS <u>5311 Edmondson Ave</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04000

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN (b) <u>Timonium</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2346 York Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> d. STREET ADDRESS <u>2346 York Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Bessie M. McConnell</u>		4. DATE OF DEATH <u>April 2, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 15, 1883</u>	9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		11. BIRTH-PLACE (Country & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joshua Jones</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Melvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Mrs. Doris F. Warehine</u> 17. INFORMANT <u>2346 York Road, Timonium</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerotic Cardiovascular Disease</u> DUE TO (b) <u>1122.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>1122.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>11 PM</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1927 YORK RD, TIMONIUM, MD.</u> 20f. (City or town) <u>Timonium</u> (County) <u>Md.</u> (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1956</u> to <u>April 1961</u> that (I) (we) last saw the deceased alive on <u>April 1st 1961</u> and that death occurred at <u>11 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. K. Quinn</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN MD</u>		22b. DATE SIGNED <u>4/4/61</u> 22d. ADDRESS <u>1927 YORK RD, TIMONIUM, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 5, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	23d. LOCATION (City, town or county) <u>Pikesville, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> <u>3631 Falls Road</u> <u>Baltimore</u> <u>Horace F. Burgee</u>		25a. REC'D BY REGISTRAR <u>APR 5 '61</u> 25b. REGISTRAR'S SIGNATURE <u>C. L. S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

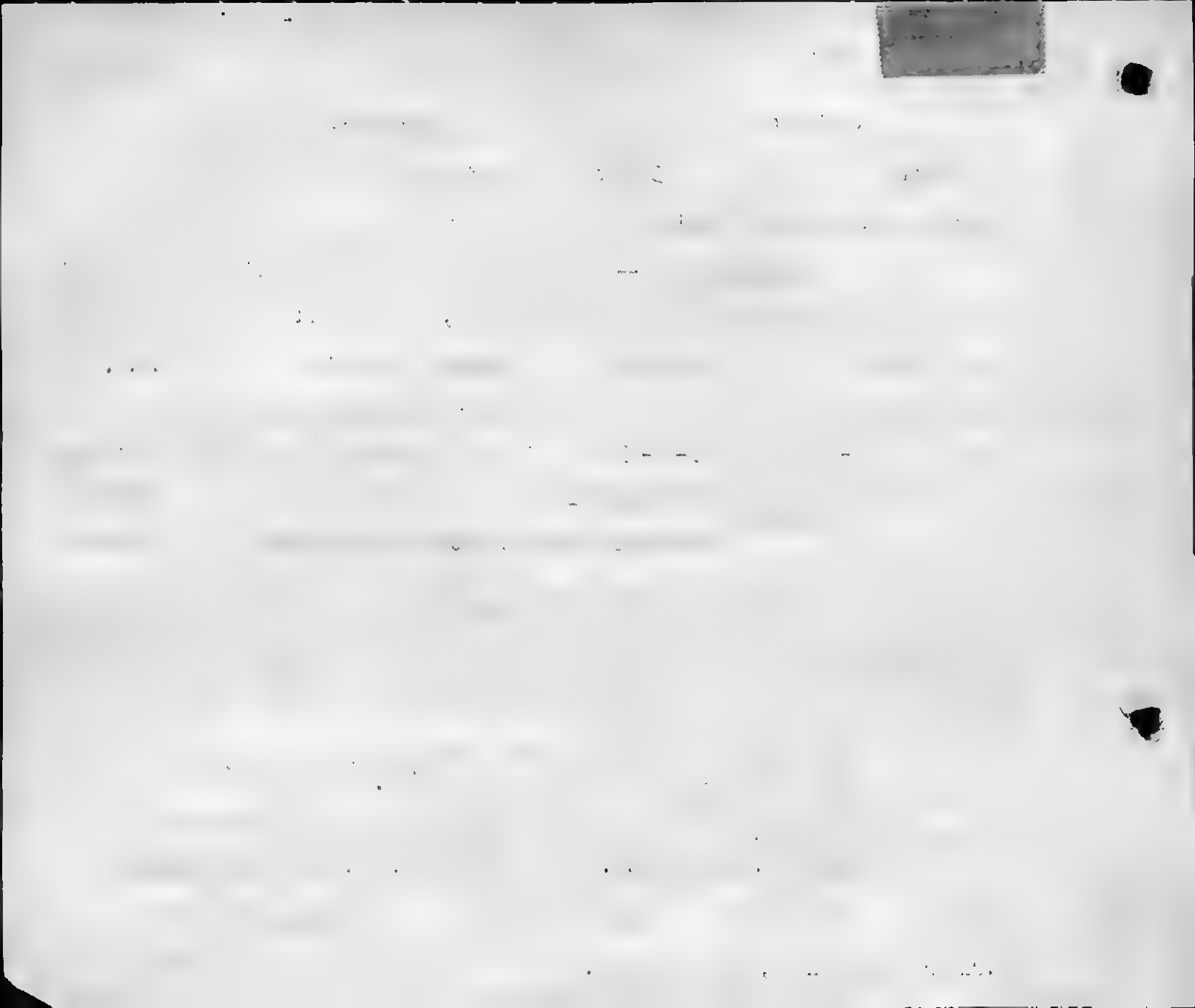
CERTIFICATE OF DEATH

04001

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b. <u>3 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Madison</u> d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FILMORE</u> <u>McCOY</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 12, 1919</u> 9. AGE (In years last birthday) <u>42</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>3</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>61</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Grain Co</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>Leesburg Georgia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>John McCoy</u> 14. MOTHER'S M maiden name <u>Alice Richardson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war/dates of service) <u>WW-11</u> 16. SOCIAL SECURITY NO. <u>253-24-7359</u> 17. INFORMANT <u>Clin Rec VAH Balto Md Ft Howard Division</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</u> (a), stating the underlying cause last. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u> UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 31, 1961</u> to <u>April 3, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 3, 1961</u> and that death occurred at <u>8:10 p.m.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Thomas F. Crahan</u> 22b. DATE SIGNED <u>4/4/61</u> 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u> 22d. ADDRESS <u>VAH BALTO, MD. FT HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/10/1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MALONE CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>MADISON, MARYLAND</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>St. Clair Funeral Home, Cambridge, Md.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>APR 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4003 Item 14 File 6204 4/27/61 ink 04002									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armcast Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>908 Rappaix Court</u>				
3. NAME OF DECEASED (Type or print) <u>Peter</u> First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-15-1868</u> 9. AGE (in years last birthday) <u>93</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> DATE OF DEATH <u>April 15 1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>employee</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>P. Lorillard Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Peter McEvoy</u> 14. MOTHER'S MAIDEN NAME <u>CATHERINE</u> unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>219-28-1498 Mrs. A. Gordon Armstrong Pratt & Montrose</u> 16. SOCIAL SECURITY NO. <u>219-28-1498</u> 17. INFORMANT <u>31 Wks</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompenation</u> DUE TO (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>April 1961</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>April 13 1961</u> , and that death occurred <u>2:30 PM</u> , from the causes and on the date stated above.				
22a. SIGNATURE <u>Charles F. O'Donnell</u> 22c. PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u> 22d. ADDRESS <u>7501 YORK RD.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-18-61</u> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> 23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD</u>					24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u> 25a. REC'D BY REGISTRAR <u>APR 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04003

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Freeland
c. LENGTH OF STAY IN b. 10 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ridge Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Freeland
d. STREET ADDRESS Ridge Rd.

3. NAME OF DECEASED (Type or print) Mary Belle McGraw
First Middle Last
4. DATE OF DEATH April 22, 1961
Month Day Year

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH Febr 22 1882
W. DOWED ☒ DIVORCED ☐ 9. AGE (In years last birthday) 79 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (State or foreign country) Tazwell Co., Va. 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Joseph Alley 14. MOTHER'S MAIDEN NAME Fanny Empsweller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO. Informant 17. ADDRESS Mrs. Hazel White, Freeland, Md. R.D.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage
445X DUE TO (b) Hypertensive Cardio Renal
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) Vascular Disease 83yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

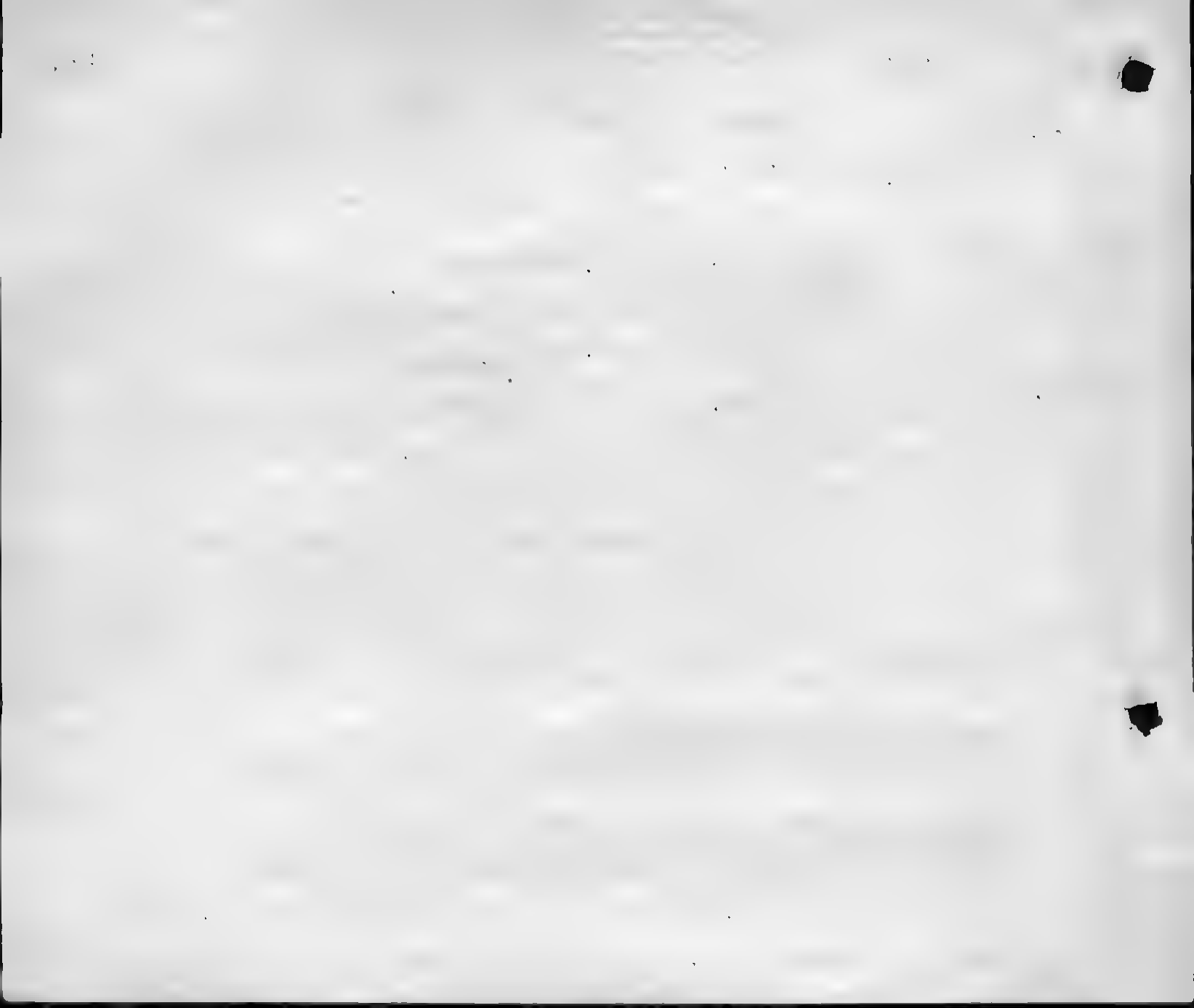
ACTUAL SIGNATURE Charles F. O'Donnell M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED 4/22/61

EXAMINER'S NAME (Type) Charles F. O'Donnell ADDRESS (Street, city, town, or county) Freeland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-25-61 22c. NAME OF CEMETERY OR CREMATORY Middletown Cemetery 22d. LOCATION (City, town, or county) (State) Freeland, Md.

23. FUNERAL DIRECTOR Jacob Hartenstein, New Freedom, Pa. ADDRESS New Freedom, Pa. 24. REC'D BY REGISTRAR APR 26 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Frank

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04004											
1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Baltimore County Mt. Wilson, Maryland Mt. Wilson State Hospital				MARYLAND 4 mos. 12 days Annapolis 101 Woodlawn Avenue							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. AGE (In years last birthday)			
Gerald William McNally				4 12 19 61				34 54 yrs.			
5. SEX				6. COLOR OR RACE				7. MARRIED			
M				W				NEVER MARRIED <input type="checkbox"/>			
8. DATE OF BIRTH				9. AGE (In years last birthday)				10. IF UNDER 1 YEAR			
11-30-06				34 54 yrs.				Months Days Hours Min.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
Ohio				U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Philip F. McNally				Amy B. Howard							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				212-28-5320				Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myoxia of heart during Pneumonectomy											
DUE TO Corinary sclerosis											
Conditions, if any, which gave rise to immediate cause (b) Empyema in right pleural space											
DUE TO pulmonary tuberculosis, far advanced											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20a. TIME OF INJURY Month, Day, Year 20b. INJURY OCCURRED 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)											
Hour a.m. None 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> Home											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R. Z. Caples M.D.											
EXAMINER'S NAME (Type) D.D. CAPLES, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country, (State))											
Burial April 16, 61 Hillcrest Cemetery Annapolis, Maryland											
23. FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE											
Hopping Funeral Home Annapolis, Md. DATE APR 17 '61 Arthur S. Kinner											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04005

4011

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN (b) <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven Conv. Home-315 Ingleside Ave. Hood Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Newton Dennison Mereness</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 25, 1868</u> 9. AGE (in years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Professor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Archivist</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mereness</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Miss Elizabeth Martindale-Same</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - CHA - CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last, (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of Item 18.) <u></u> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> <u>1961</u> , to <u>4/17</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>4/17</u> <u>1961</u> , and that death occurred at <u>8:15 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u> M.D.		22b. DATE SIGNED <u>4/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		22d. ADDRESS <u>5800 E. DIMMICK AVE. BALDWIN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 19, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) <u>Pikesville, Maryland</u> (State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u></u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>William L. Kline</u>	
DATE <u>APR 19 1961</u>		DATE <u>APR 19 1961</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

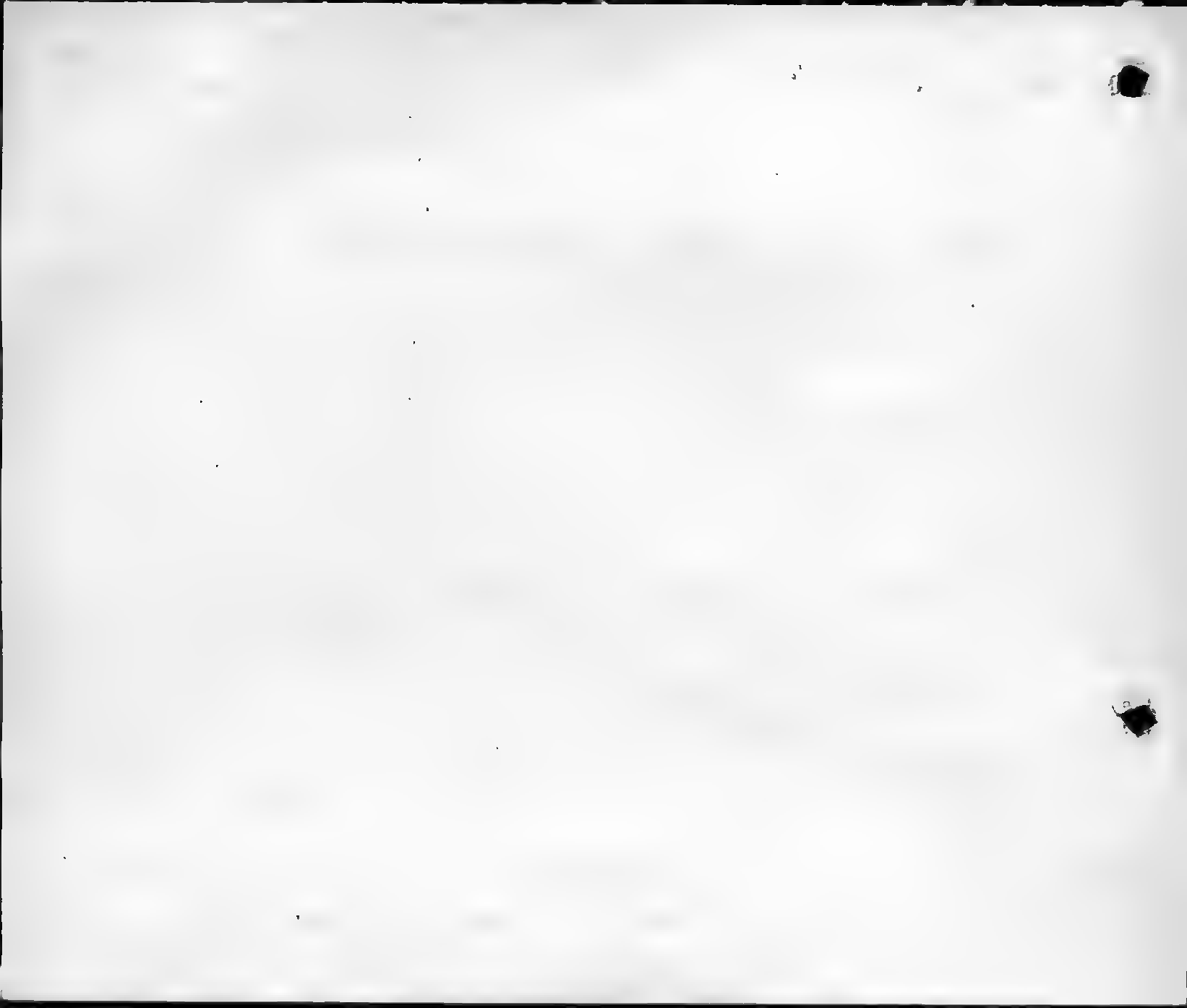


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4012
CERTIFICATE OF DEATH
04006

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 10 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 1409 N. BROADWAY.	
3. NAME OF DECEASED (Type or print) First BERTHA Middle DOVE Last MILLER		4. DATE OF DEATH Month APRIL Day 13 Year 1961	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1878
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM EDWARD GREGGON		14. MOTHER'S MAIDEN NAME ISABEL A. CARROLL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 212-28-6668 D	
17. INFORMANT Frank L. Smith		Address Cockeysville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio DUE TO Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 1-13 1962 to 4-13 1961 , that (I) (we) last saw the deceased alive on 4-12 1961 , and that death occurred at 4 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 4/13/61	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.		25a. REC'D BY REGISTRAR DATE APR 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

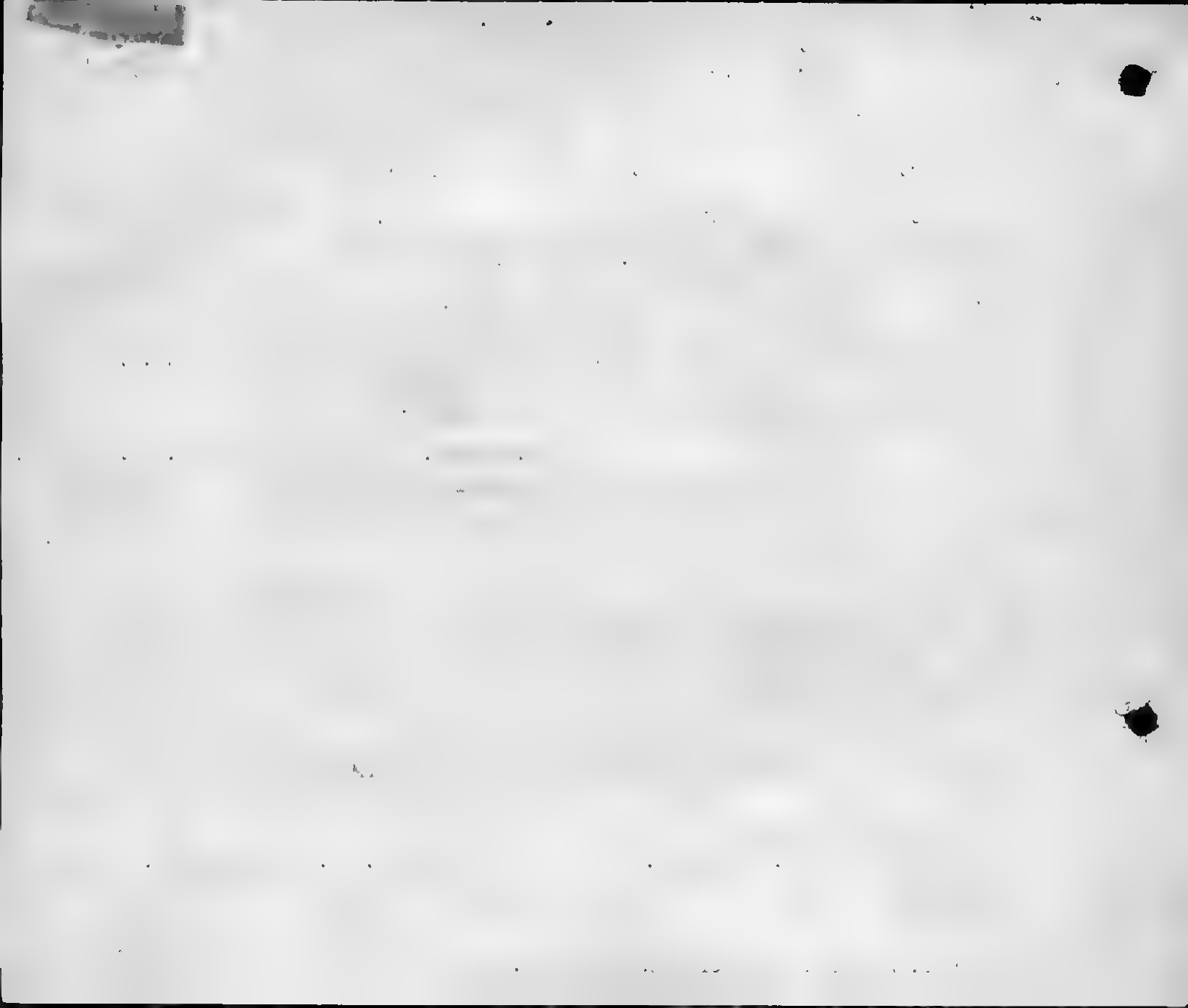
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04007

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 347 E. 29th Street	
3. NAME OF DECEASED (Type or print) JAMES W. MILLER		4. DATE OF DEATH Month April Day 10 Year 1961	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker		9. AGE (In years last birthday) 66 yr	
10. USUAL BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles S. Miller	
14. MOTHER'S MAIDEN NAME Mary E. Dietrich		15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (Yes, no, or unknown (If yes give year of service)) WW I	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Records. VA Hospital, Balto. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RIGHT LOWER LOBE PNEUMONITIS, CAUSE UNKNOWN 053.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) SEPTICEMIA (c), stating the underlying cause last, DUE TO (c) UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) OSTEOMYELITIS RIGHT FIRST METATARSAL JOINT		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 1, 1961 to April 10, 1961 , that (X) (we) last saw the deceased alive on April 10, 1961 and that death occurred at 9:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 4/11/61	
22c. PHYSICIAN'S NAME (Typed) THOMAS F. CRAHAN, M. D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-14-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry F. Jenkins		25a. REC'D BY REGISTRAR APR 12 '61	
25b. REGISTRAR'S SIGNATURE C. L. S. Thomas		25c. ADDRESS 4906 York Rd. Balto. Md.	

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04008**

2014

1. PLACE OF DEATH a. COUNTY <u>BALT. more</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balti</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			c. LENGTH OF STAY in 1b <u>7 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2936 PCTY HILL Ave</u>				d. STREET ADDRESS <u>14900 Hartford Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LUCIA</u> Middle <u>A</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1961</u>									
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11 - 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
Hours	Min												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AD Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13. FATHER'S NAME <u>Rev John Hooper</u>				14. MOTHER'S MARDEN NAME <u>Margaret Newman</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Louise Basham</u>		Address <u>4900 Hartford Rd</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 10, 1955</u> to <u>April 29, 1961</u> , that I last saw the deceased alive on <u>April 27, 1961</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above <div style="display: flex; justify-content: space-between;"> <div> ACTUAL SIGNATURE <u>George Sawyer</u> M.D. </div> <div> ADDRESS (Street, city or town, state) <u>4308 Hartford Rd</u> </div> <div> DATE SIGNED <u>5/1/61</u> </div> </div> <div style="display: flex; justify-content: space-between;"> <div> PHYSICIAN'S NAME (Type) <u>GEORGE SAWYER</u> </div> <div> <u>4808 Hartford Rd</u> </div> </div>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 2 - 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & Son</u>				ADDRESS <u>8802 Hartford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '61</u>							
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>													

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04009**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rees., 116 German Hill Rd. 22, Md.				d. STREET ADDRESS 116 German Hill Rd. 22, Md.			
3. NAME OF DECEASED (Type or print) First Anthony Middle ALFREDO Last Milsi				4. DATE OF DEATH Month 4 Day 8 Year 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1898		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wire mill		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO. 213-07-3335		17. INFORMANT Address Mrs. Margaret Rose Milsi 116 German Hill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C. Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-1961		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or county) (State) German Hill Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA				ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR DATE APR 13 '61	
				24b. REGISTRAR'S SIGNATURE William S. Hanna			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, place "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

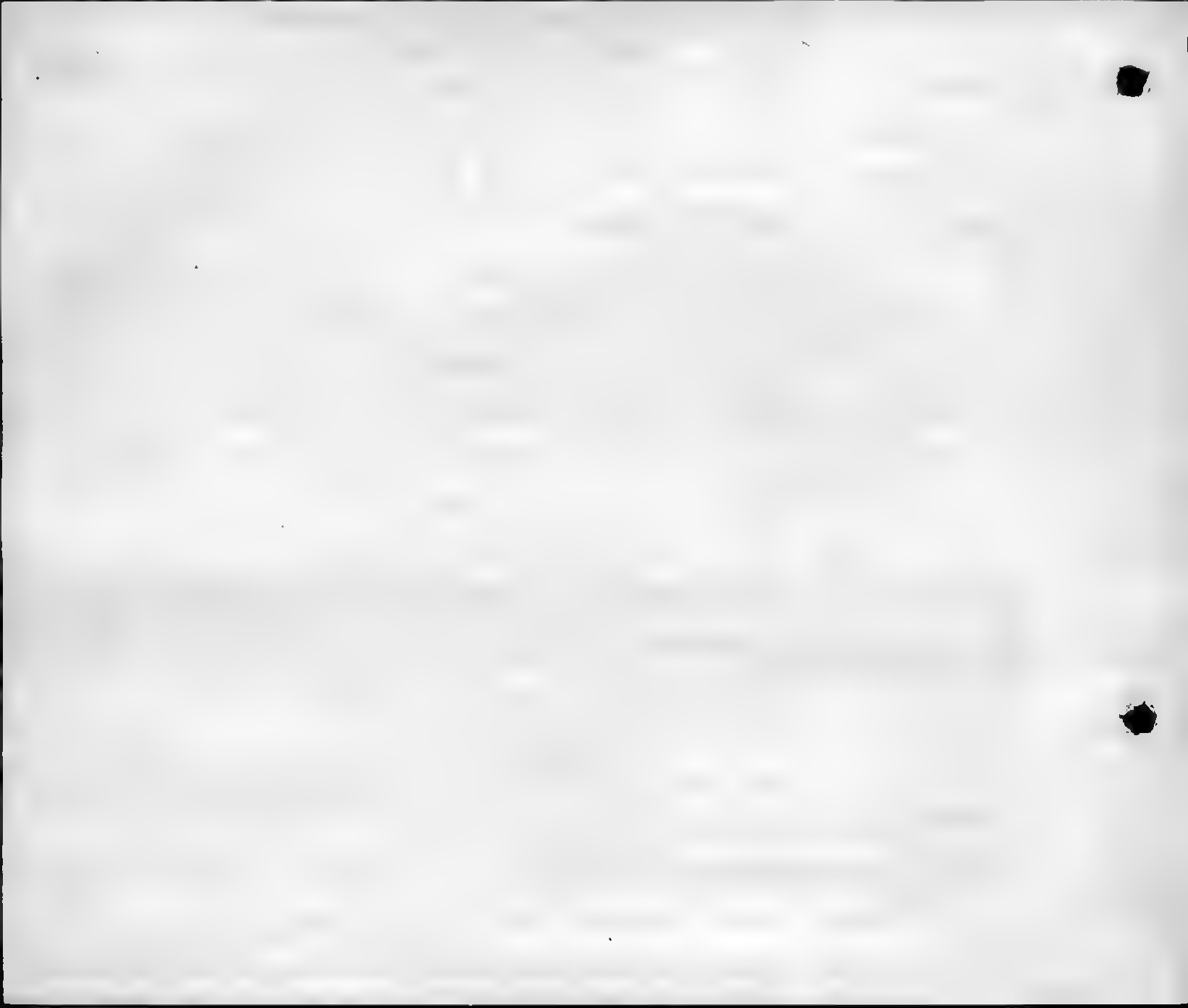
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Items 5 & 6 Film C287 5/15/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 04010

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 yr.</u>		d. STREET ADDRESS <u>227 Detroit Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth</u> <u>Minutelli</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>28</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 18, 1870</u>
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>RUGGERIO Cupoli</u>		14. MOTHER'S MAIDEN NAME <u>CARMEN CAIRELLI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Mary D'Ambrasio</u>		Address <u>227 Detroit Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardio-vascular disease</u> DUE TO (c) <u>Generalized arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs</u> <u>30 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1961</u> to <u>April</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/20</u> , 19 <u>61</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4-2</u>			
ACTUAL SIGNATURE <u>Eugene F. Navy</u> M.D.		PHYSICIAN'S NAME (Type) <u>Eugene F. Navy</u> <u>7001 Mornington Rd Dundalk 22, Md</u>	
22a. BURIAL/CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/5/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>	22d. LOCATION (City, town, or county) (State) <u>CHARLESBURG, W. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Zannone Jr</u> ADDRESS <u>312 S. Highland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 8 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04011

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre deGrace, Maryland	
f. STREET ADDRESS 456 Green Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle W. Last Mitchell		4. DATE OF DEATH Month Apr. Day 2 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 8, 1868
9. AGE (In years last birthday) 93 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) father		12. KIND OF BUSINESS OR INDUSTRY Retired	
13. FATHER'S NAME John Mitchell		14. MOTHER'S MAIDEN NAME Addie Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 214-16-6310	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complications from prostate carcinoma DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Cardiomyopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Year 1961 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 22, 1961 to April 2, 1961 , that (I) (we) lost saw the deceased alive on April 2, 1961 , and that death occurred at 4:40 P. M. from the causes and on the date stated above			
22a. SIGNATURE H. I. Cholmondeley		22b. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland	
22c. PHYSICIAN'S NAME (Type) H. I. Cholmondeley		22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b. DATE THEREOF 4-5-1961	
23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cem		23d. LOCATION (City, town, or county) (State) Havre de Grace Md	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		25a. REC'D BY REGISTRAR DATE APR 6 '61	
25b. REGISTRAR'S SIGNATURE C. L. S. F. F. F.		25c. REGISTRAR'S SIGNATURE C. L. S. F. F. F.	

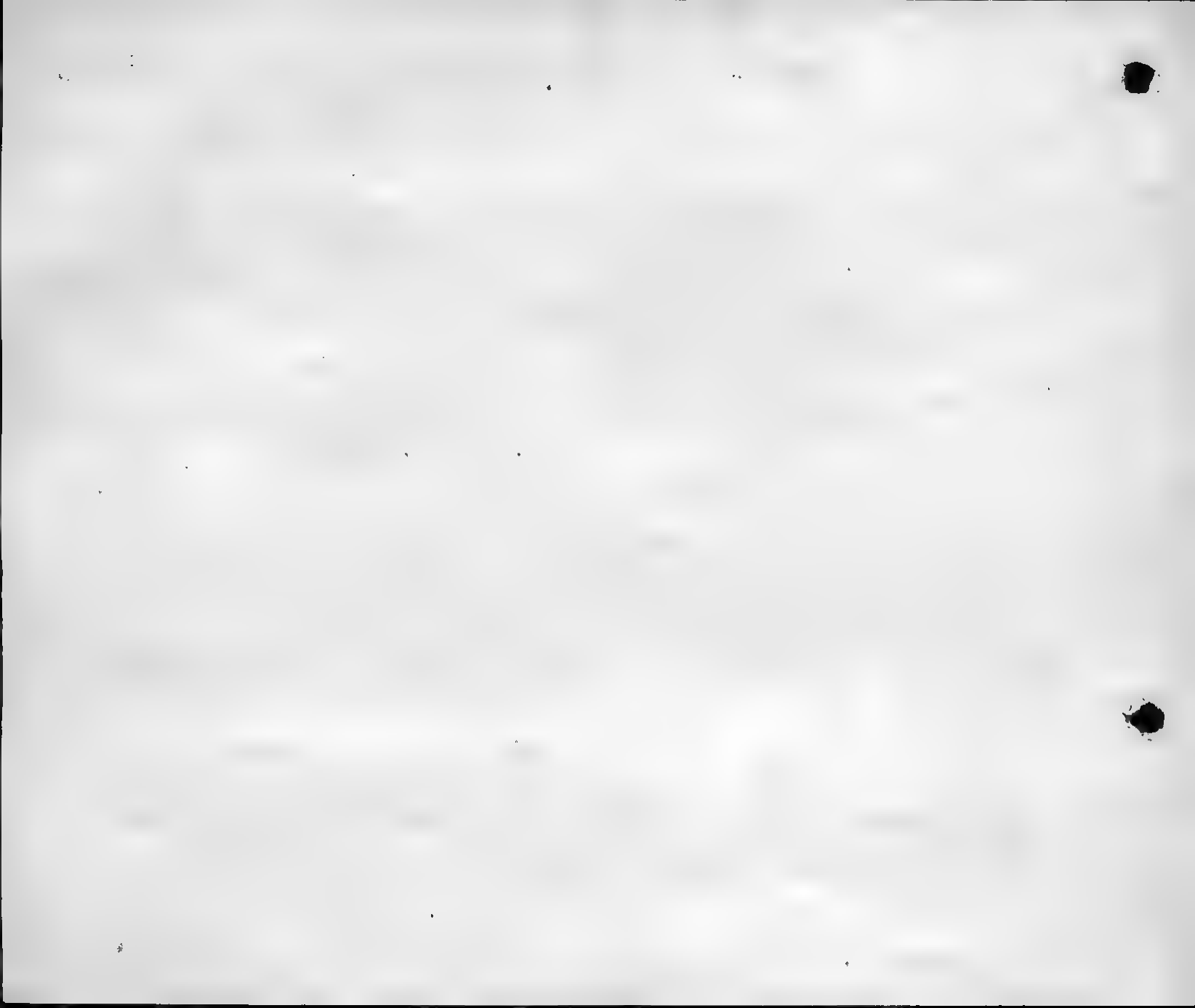


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4018
CERTIFICATE OF DEATH
04012

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4140 Beechwood Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>4140 Beechwood Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary Ellen Mitchell</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>July 8, 1879</u> 8. AGE (In years, last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.		9. AGE (In years, last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Mingo Junction, Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Cleary</u> 14. MOTHER'S MAIDEN NAME <u>Mary Roach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Otto H. Duker, 3rd,</u> Address <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 27. DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Had a previous Cerebral Hemorrhage 1960</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>20 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>June 4, 1961</u> <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1961</u> to <u>April 8, 1961</u> that (I) (we) last saw the deceased alive on <u>Apr 7, 1961</u> , and that death occurred at <u>1400</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Morris G. Jacobs</u> 22c. PHYSICIAN'S NAME (Type) <u>Morris A. Jacobs M.D.</u>		22b. DATE SIGNED <u>4/8/61</u> 22d. ADDRESS <u>1010 North Point Rd. Belth 24 Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04013**

1 PLACE OF DEATH a. COUNTY BALTO Co MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD b. COUNTY BALTO Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3013 MORE LAND AVE		d. STREET ADDRESS 3013 MORE LAND AVE	
3 NAME OF DECEASED (Type or print) First Middle Last DANIEL MORFE		4. DATE OF DEATH Month Day Year APRIL 1 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-1876
9 AGE In years last birthday 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11 BIRTHPLACE (State or foreign country) ITLY		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DOMINIC MORFE		14 MOTHER'S MAIDEN NAME UNKNOWN	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 219-01-3118	
17 INFORMANT FRANK MORFE		Address 3201 Chesley Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Congestive failure (b) Fibrosis with silicosis severe (c) and myocardial degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2-3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 1 , 19 61 , to Apr 2 , 19 61 , that I last saw the deceased alive on Apr 1 , 19 61 , and that death occurred at 7:10 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Frank G. Kasik Jr. M.D. 3005 Harford Road PHYSICIAN'S NAME (Type) Dr. Frank T. Kasik, Jr. Baltimore 14, Md.			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-61	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		22d LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE C. F. EVANS & SON		ADDRESS 8802 NANTOKU RD.	
24a. REC'D BY REGISTRAR DATE APR 4 '61		24b REGISTRAR'S SIGNATURE Curtis E. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
TSM 9/59

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4020
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH
04014

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Maryland Ave.		d. STREET ADDRESS 1408 MARYLAND AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW B MUELLER (MILLER)		4. DATE OF DEATH Month Day Year APRIL 11 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 10, 1894
9. AGE (in years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crain Operator		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Mueller		14. MOTHER'S MAIDEN NAME Eva Bartell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no., or unknown) (If yes, give war or dates of service) 216-10-3181		16. SOCIAL SECURITY NO. 216-10-3181	
17. INFORMANT CONSTANCE MUELLER (same as above)		Address (same as above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GASTRIC HEMORRHAGE DUE TO (b) GASTRIC ULCER DUE TO (c) 2 WEEKS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, HYPERTENSION, OLD HEMIPLEGIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 16, 1950 to APR. 11, 1961 , that (I) (we) last saw the deceased alive on APR. 10, 1961 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph M. Miller		22b. DATE SIGNED 4/14/61	
22c. PHYSICIAN'S NAME (Type) JOSEPH MILLER MD		22d. ADDRESS 108 S. TAYLOR AVE BALTO MD	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-14-61	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		25a. REC'D BY REGISTRAR DATE APR 17 '61	
ADDRESS 418 Eastern Blvd.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



4021

04015

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN TB Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4214 Cardwell Ave.				d. STREET ADDRESS 4214 Cardwell Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence L. Mullen		First Middle Last		4. DATE OF DEATH Month Day Year April 21, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1904	
9. AGE (In years last birthday) 56 yrs		10. JSUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Consultant		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry L. Mullen				14. MOTHER'S MAIDEN NAME Mary Butler			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 218-10-6789		17. INFORMANT Mrs. Mary M. Mullen 4214 Cardwell Ave. 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Carcinoma Cholangiolytic with metastasis to Lf Lung. 3 months interval between onset and death					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to Apr 1961, that (I) (we) last saw the deceased alive on Apr 1961, and that death occurred at M, from the causes and on the date stated above							
22a. SIGNATURE Frank T. Kasik				M.D. ATTENDING PHYS. 22d. ADDRESS 9005 Harford Rd		22b. DATE SIGNED 4/24/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-1961		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Sassah Funeral Home				25a. REC'D BY REGISTRAR DATE APR 26 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VI A15 (4)
ISM 9/60

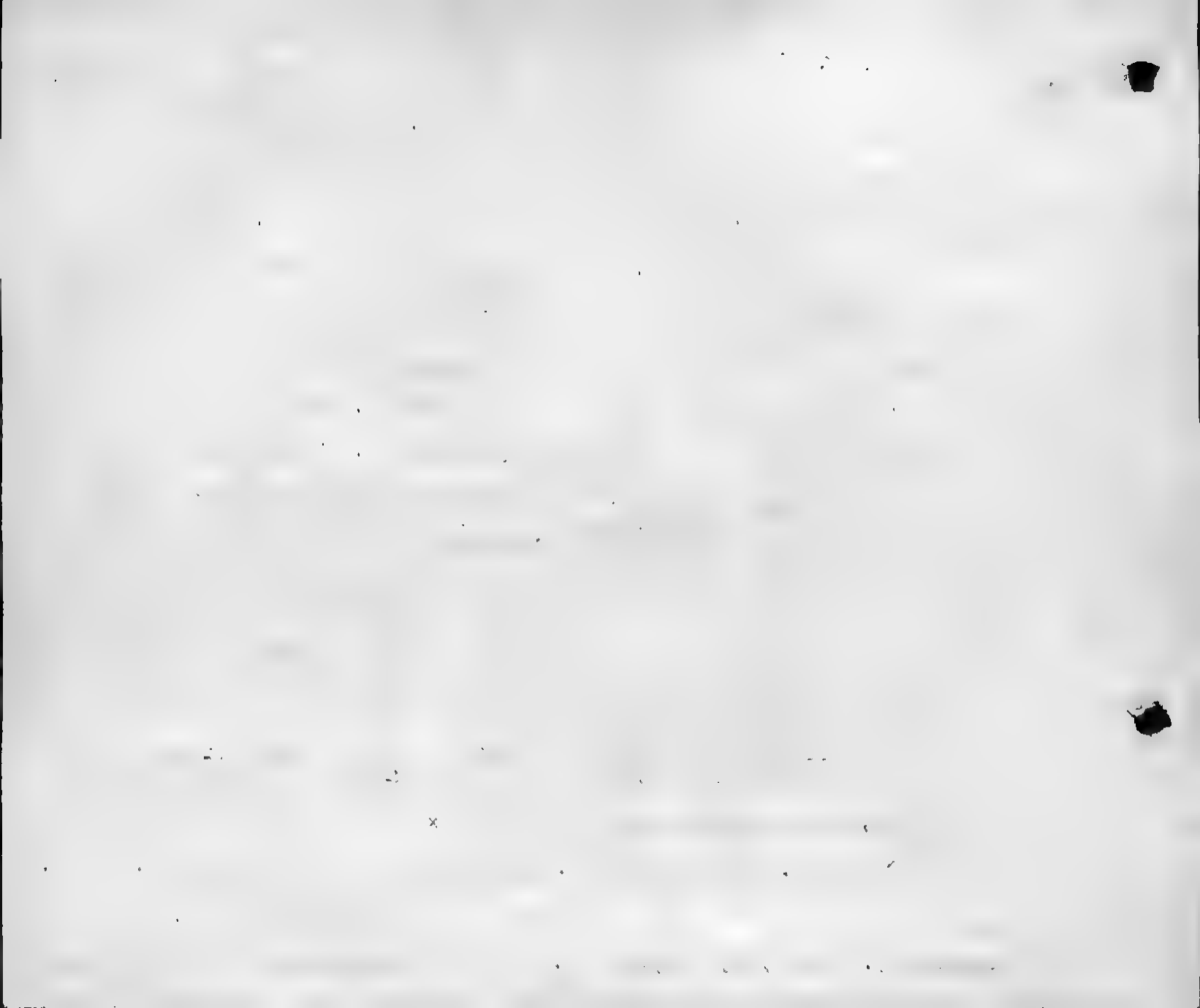
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4022											
04016											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>						c. LENGTH OF STAY IN 1b <u>Parkville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2829 Linwood Ave.</u>						d. STREET ADDRESS <u>2829 Linwood Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>Margaret</u>						4. DATE OF DEATH <u>April 23 19 61</u>					
5. SEX <u>female</u>						6. COLOR OR RACE <u>white</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>M. Murphy</u>						8. DATE OF BIRTH <u>10 -28-1882</u>					
9. AGE (In years last birthday) <u>78</u> yrs.						10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>						12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>John J. Murphy</u>						14. MOTHER'S MAIDEN NAME <u>Margaret A. Hunt</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>1</u>					
17. INFORMANT <u>Mrs Gertrude M. McWilliams</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longstanding heart failure & pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u>						<u>unknown</u>					
DUE TO (c) <u>Arteriosclerosis</u>						<u>unknown</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>11/4</u> 1955 to <u>April 22 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 22</u> 1961, and that death occurred at <u>2</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles R. Goldsborough</u> M.D.											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>Charles R. Goldsborough, M.D.</u>											
22d. ADDRESS <u>2923 Saint Paul Street Balto. 18, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>											
23b. DATE THEREOF <u>4-26-61</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore, Md.</u>											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>											
25a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

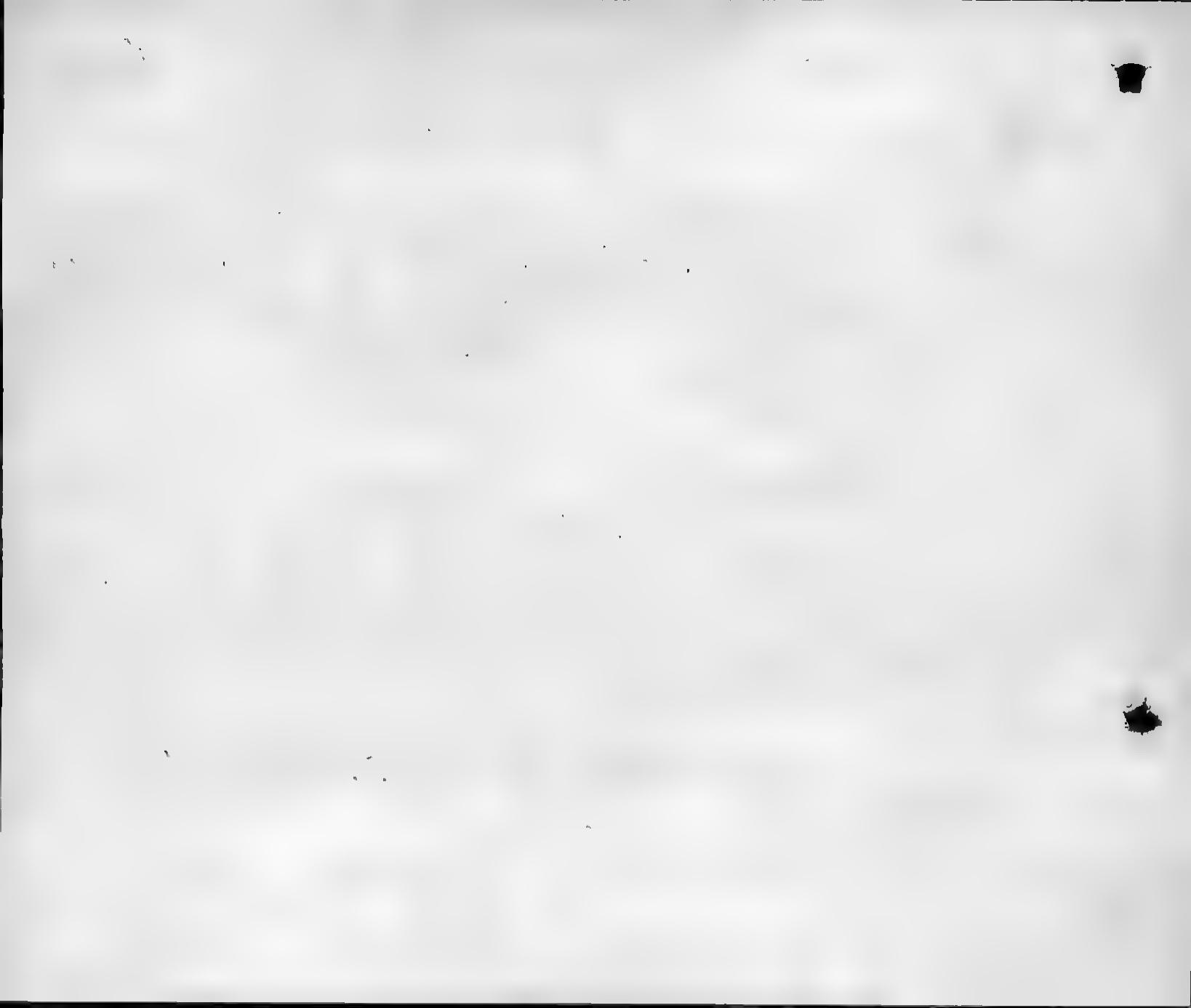
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4023

Items 8 & 9 Film G285 4/24/61 iwk

04017

1. PLACE OF DEATH a. COUNTY BALTIMORE b. STATE MARYLAND c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) STEMMERS RUN LIFE 7121 GOLDEN RING ROAD.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) STEMMERS RUN 7121 GOLDEN RING ROAD. d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM M Detrick NAKE First Middle Last 4. DATE OF DEATH April 16 1961 Month Day Year		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1906 AGE (In year last birthday) 54 yrs. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Company 10b. KIND OF BUSINESS OR INDUSTRY Gas Electric Co.		11. BIRTHPLACE (County & State, or foreign country) BALTO CITY 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Nake 14. MOTHER'S MAIDEN NAME Anna Ripken	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 12-05-2993 17. INFORMANT Mrs Emily Nake Address 7121 Golden Ring Rd.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crownary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardio Vascular Disease DUE TO (b) ? DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from April 15, 1961 to April 16, 1961 , that (I) (we) last saw the deceased alive on April 15, 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.		22a. SIGNATURE W. M. Gardner M.D. 22c. PHYSICIAN'S NAME (Type) Balto 6 Md.		22b. DATE SIGNED 4/16/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF April 19, 1961 23c. NAME OF CEMETERY OR CREMATORY ZION LUTHERAN Cem. 23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND		24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road #6 25a. REC'D BY REGISTRAR APR 19 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 14 Baltimore 4/25/61 jwk

CERTIFICATE OF DEATH

Reg. Dist. No.

04018

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 14</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8820 Old Harford Rd.</u>				d. STREET ADDRESS <u>18820 Old Harford</u>			
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Margaret Amelia Nesline</u>				4. DATE OF DEATH <u>Apr 22 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>			
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Peter Emge</u>				14. MOTHER'S MAIDEN NAME <u>Roseland Ziegler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Daughter</u>			
17. INFORMANT <u>Daughter</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Myocardial degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery disease</u> (c) <u>Senile Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a) <u>Senile Arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Apr</u> Day <u>22</u> Year <u>1961</u> Hour <u>9</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1953</u> to <u>Apr 1961</u> that I last saw the deceased alive on <u>Apr 18 1961</u> and that death occurred at <u>100 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Rd BALTO 14 Md.</u>			
DATE SIGNED <u>4/22/61</u>							
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-25-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lanahan Jan W Jones</u>				ADDRESS <u>7401 Belair Rd.</u>			
24a. REC'D BY REGISTRAR <u>DATE APR 26 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Callahan & H...</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. **04019**

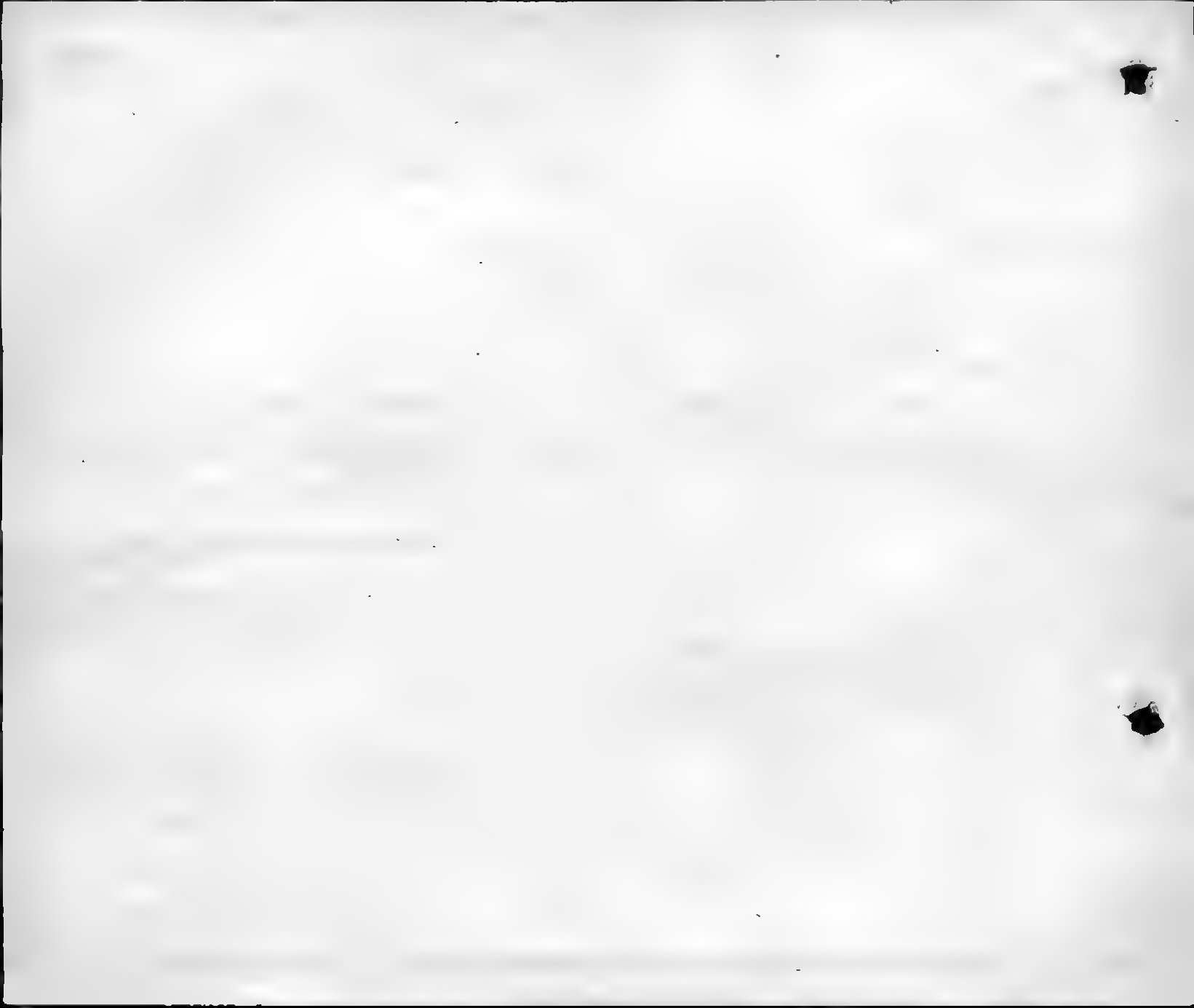
4025

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FOREST HAVEN N.H.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK d. STREET ADDRESS BALTIMORE AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES A. OSTENDORF First Middle Last 4. DATE OF DEATH APRIL 2 1961 Month Day Year		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 24, 1884 9. AGE (In years (last birthday) yrs. 76 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH F. OSTENDORF 14. MOTHER'S MAIDEN NAME JOHANNA RETHMAN 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. — 17. INFORMANT Address JADIE HERRMANN, 221 PINEWOOD AVE.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC EMACIO-URSCUR 4221 DUE TO ARTERIO SCLEROTIC EMACIO-URSCUR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEART DISEASE DUE TO HEART DISEASE (c) HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 6/1 19 59 , to 4/3 19 61 , that I last saw the deceased alive on 4/3 19 61 , and that death occurred at 11:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John H. Shaw M.D. 5804 EDWARDS AVE. 4/3/61 PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D. BALTIMORE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 4-6-61 22c. NAME OF CEMETERY OR CREMATORY SACRED HEART 22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WILBERT FUNERAL HOME 2112 DUNDALK AVE 24a. REC'D BY REGISTRAR DATE APR 10 '61 24b. REGISTRAR'S SIGNATURE Clifford S. Thomas	

Page 47

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

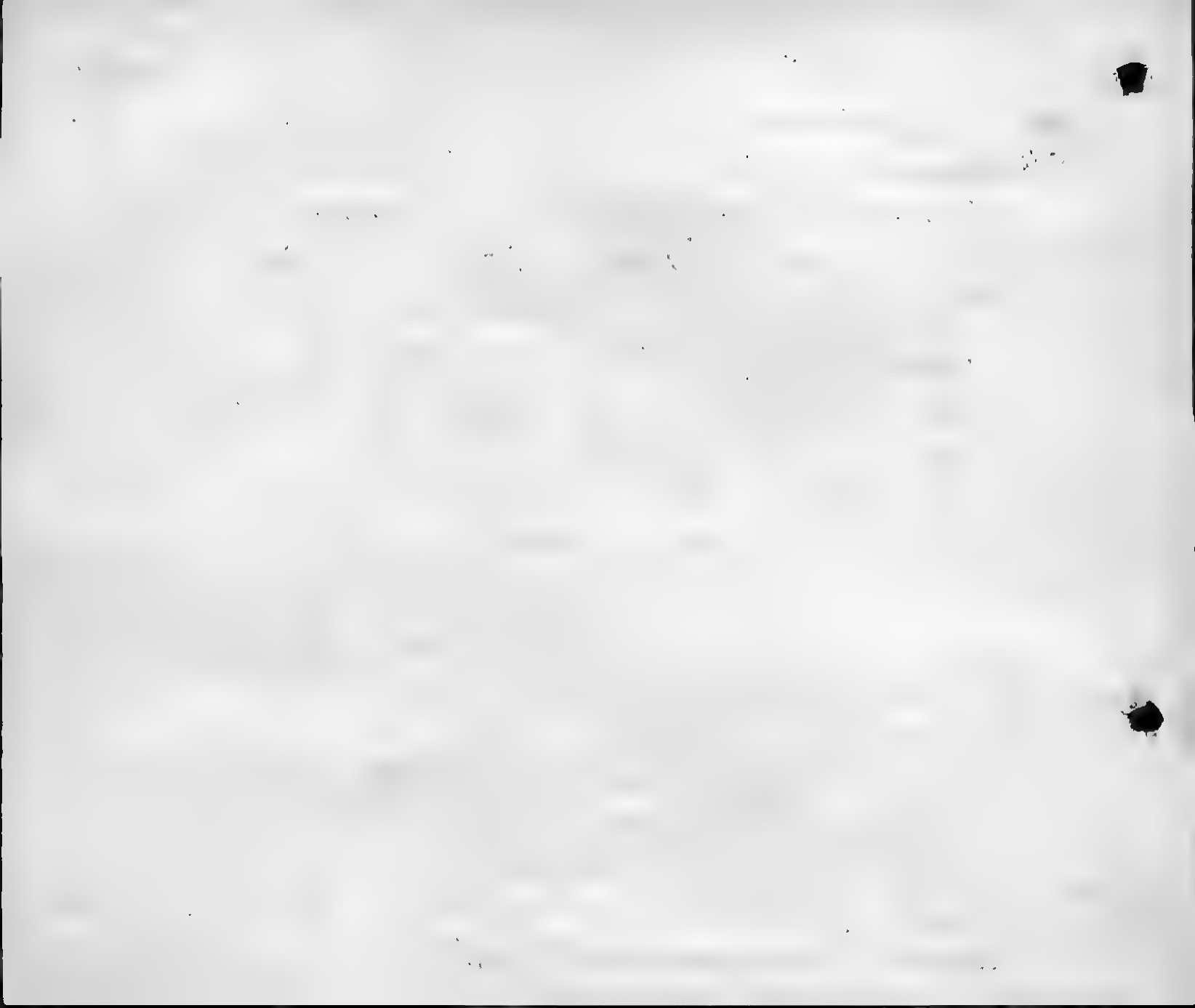
CERTIFICATE OF DEATH

4026

04020

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Baltimore 12 mi</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armacost Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>329 Rosebank Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN HENRY OTTO</u>				4. DATE OF DEATH Last <u>April</u> Month <u>27</u> Day <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1882</u>	
9. AGE (in years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas & Electric Co. Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Simon Otto</u>				14. MOTHER'S MAIDEN NAME <u>Anna M. Koch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-05-6627</u>			
17. INFORMANT <u>John R. Otto</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 153.9 DUE TO <u>large Bowel</u> Conditions, if any, which gave rise to immediate cause (b) <u>large</u> (c) <u>4 yrs</u> (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June 1948</u> to <u>April 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 26, 1961</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D. 22b. DATE SIGNED <u>4/28/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u> 22d. ADDRESS <u>7501 York Rd. Towson, Md</u>							
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>April 29, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd</u> 25a. REC'D BY REGISTRAR <u>MAY 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

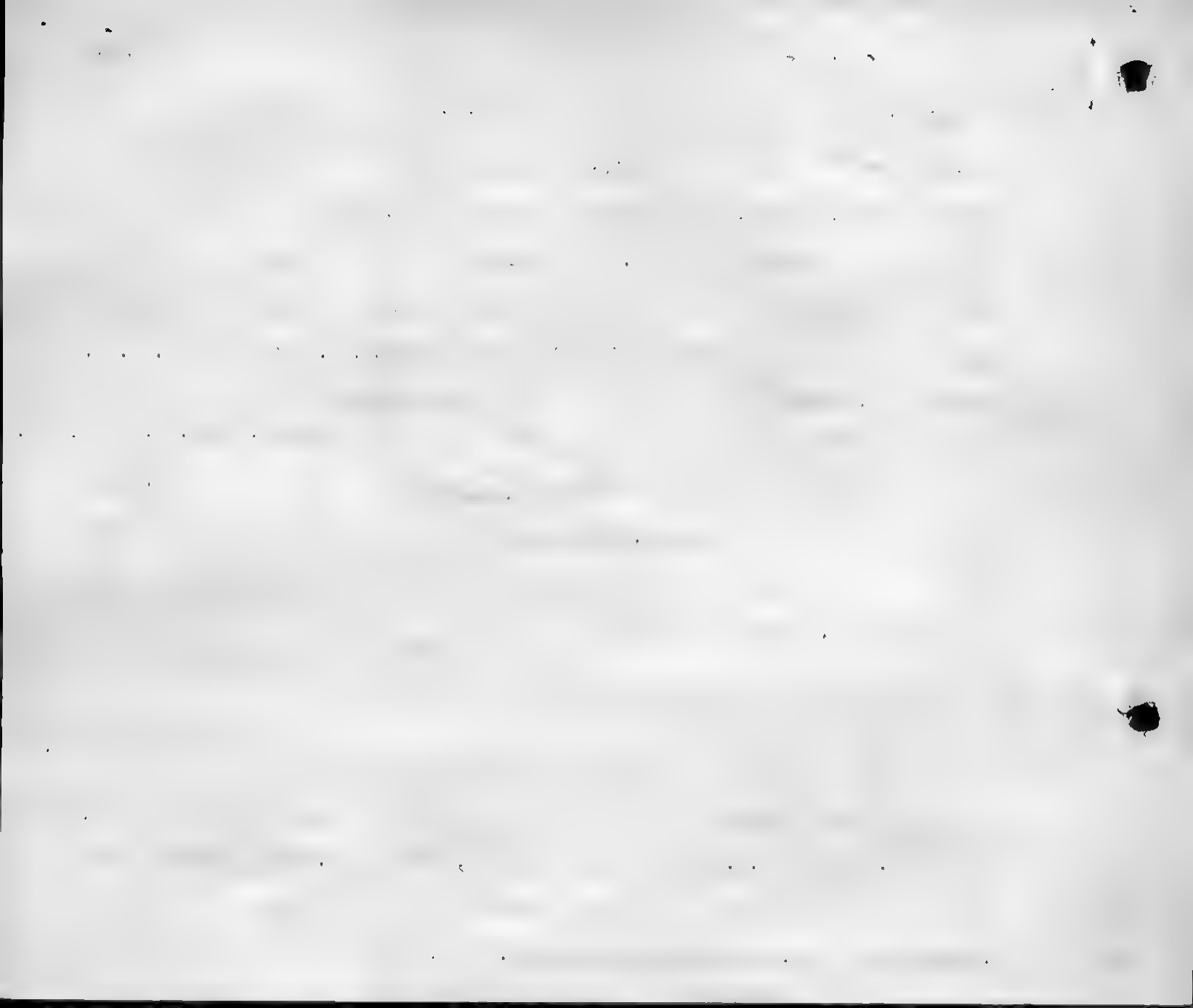
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4027

04021

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) STATE Maryland b. COUNTY Lansdowne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 207 Fourth Avenue	
3. NAME OF DECEASED (Type or print) Lonnie G. Parker		4. DATE OF DEATH Month April Day 26 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1901
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Repair Shop	
11. BIRTHPLACE, County & State Craven County, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Sylvester G. Parker		14. MOTHER'S MAIDEN NAME Elizabeth Ballard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 239-16-9194	
17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE, MASSIVE DUE TO Conditions, if any, which gave rise to immediate cause (b) CARCINOMA, RIGHT LUNG DUE TO (c) LUNG ABSCESS, RIGHT MID LUNG		INTERVAL BETWEEN ONSET AND DEATH ACUTE 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 12, 1961 to April 26, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 26, 1961 , and that death occurred at A. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Crahan</i>		22b. DATE SIGNED 4/26/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4-27-61	23c. NAME OF CEMETERY OR CREMATORY Bridgeton Cemetery	23d. LOCATION (City, town or county) (State) New Bern, North Carolina
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Road, Balto. 14, Md.		25a. REC'D BY REGISTRAR MAY 1 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
ISM 11/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4028

04022

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The House In The Pines-16FustingAve</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY E. PARKS</u> First Middle Last				4. DATE OF DEATH <u>April 17 1961</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours M n.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>John Bauer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth horn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>*****</u>			
17. INFORMANT <u>Mrs. Lillian Ennis-6439Gaul1 S.E. L.C.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Cor. Artery Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cor. Artery Disease</u> (c) <u>Cor. Artery Disease</u> stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>3-18-61</u>, to <u>4-17-61</u>, that (I) (we) last saw the deceased alive on <u>4-15-61</u>, and that death occurred at <u>4:30 PM</u>, from the causes and on the date stated above.							
22a. SIGNATURE <u>William K. Gallager</u>				22b. DATE SIGNED <u>APR 21 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>William K. Gallager, M.D.</u>				22d. ADDRESS <u>6207 Frederick Rd, Baltimore 22, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. B. Neppert</u>				25a. REC'D BY REGISTRAR <u>1300 Eubaw Place</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				DATE <u>APR 21 '61</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)
15M 9/59

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04023

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) Arthur First Yellott Middle Pindell Last				4. DATE OF DEATH Month APRIL Day 17 Year 1961			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 23, 1882		9. AGE (In years last birthday) 78 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY C. & P. TELEPHONE		11. BIRTHPLACE (State or foreign country) BALTIMORE Co.	
13. FATHER'S NAME REV. ADOLPHUS T. PINDELL				14. MOTHER'S MAIDEN NAME JANE YELLOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT MR. ARTHUR Y. PINDELL COCKEYSVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung, lt. upper lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 163X DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Aug 1960			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic hypertrophy				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 15, 1960 to April 17, 1961 , that (I) (we) last saw the deceased alive on April 12, 1961 , and that death occurred at 4:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Elizabeth B. Sherrill M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill, M.D.				22d. ADDRESS Cockeysville, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/19/61		23c. NAME OF CEMETERY OR CREMATORY SHERWOOD		23d. LOCATION (City, town, or county) (State) COCKEYSVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. MEARS & SON				ADDRESS 805 N. CALVERT ST.		25a. REC'D BY REGISTRAR DATE APR 19 '61	
				25b. REGISTRAR'S SIGNATURE Arthur P. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

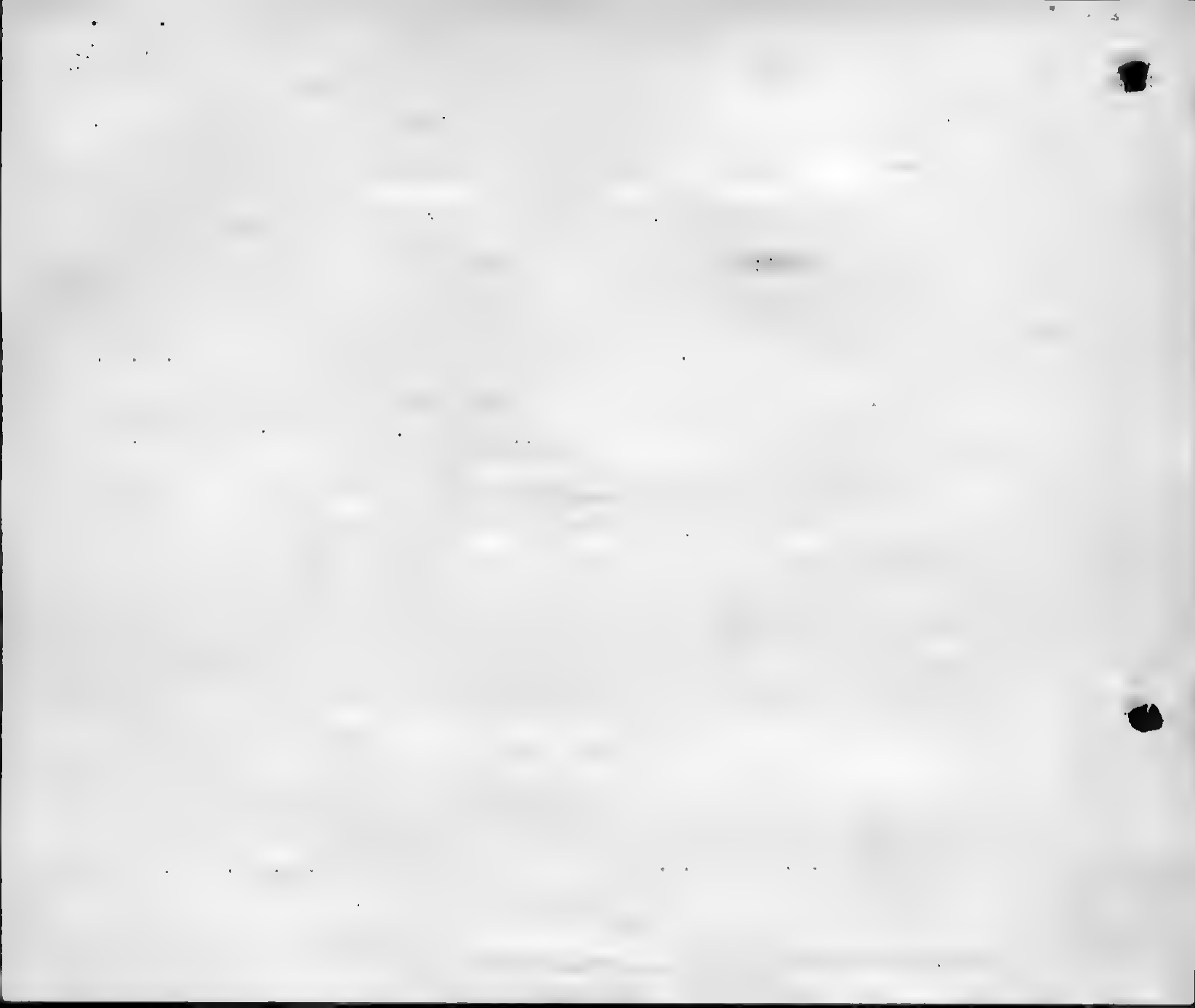
4030

04024

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>9 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>37 Larkin Street</u>	
3. NAME OF DECEASED (Type or print) <u>ALFRED</u> First Middle Last		4. DATE OF DEATH <u>April 27 1961</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 5, 1897</u> Yrs.	
9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR: Months Days Hours Min.		10. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Academy</u>	
11. BIRTHPLACE County & State, or foreign country <u>East Polaka, Florida</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Franklin Pinkston</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>WW I</u>	
17. INFORMANT <u>Clinical Records, VAH, Baltimore 18, Md.</u> <u>FORT HOWARD DIVISION</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>CARCINOMA OF PANCREAS WITH METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized. Diabetes Mellitus</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>1 YEAR</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County, (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>April 18 1961</u> to <u>April 27 1961</u> , that (X) (we) last saw the deceased alive on <u>April 27 1961</u> , and that death occurred at <u>3:05 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Crahan</u>		22b. DATE SIGNED <u>4/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>		22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial 5-2-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National</u>	
23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Reese Mortuary, Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04025

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY Bal o.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY IN TB 10		d. STREET ADDRESS 10 Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 Catonsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenly Bennett Pittinger		4. DATE OF DEATH Month April Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1896
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Electric Co		10b. KIND OF BUSINESS OR INDUSTRY Ind	
11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pittinger		14. MOTHER'S MAIDEN NAME Bennet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 29 28 1463	
17. INFORMANT Edeline Wolle ribbon		Address 1010 Lee	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) 4201 DUE TO Coronary thrombosis (c) 4201 DUE TO Coronary thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201 DUE TO Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. W. McKieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/1/61	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or country) (State) Balt. Md	
23. FUNERAL DIRECTOR Mac Nott & Son		ADDRESS Catonsville	
24a. REC'D BY REGISTRAR MAY 3 '61		24b. REGISTRAR'S SIGNATURE Charles L. Hume	

VS. A15ME
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

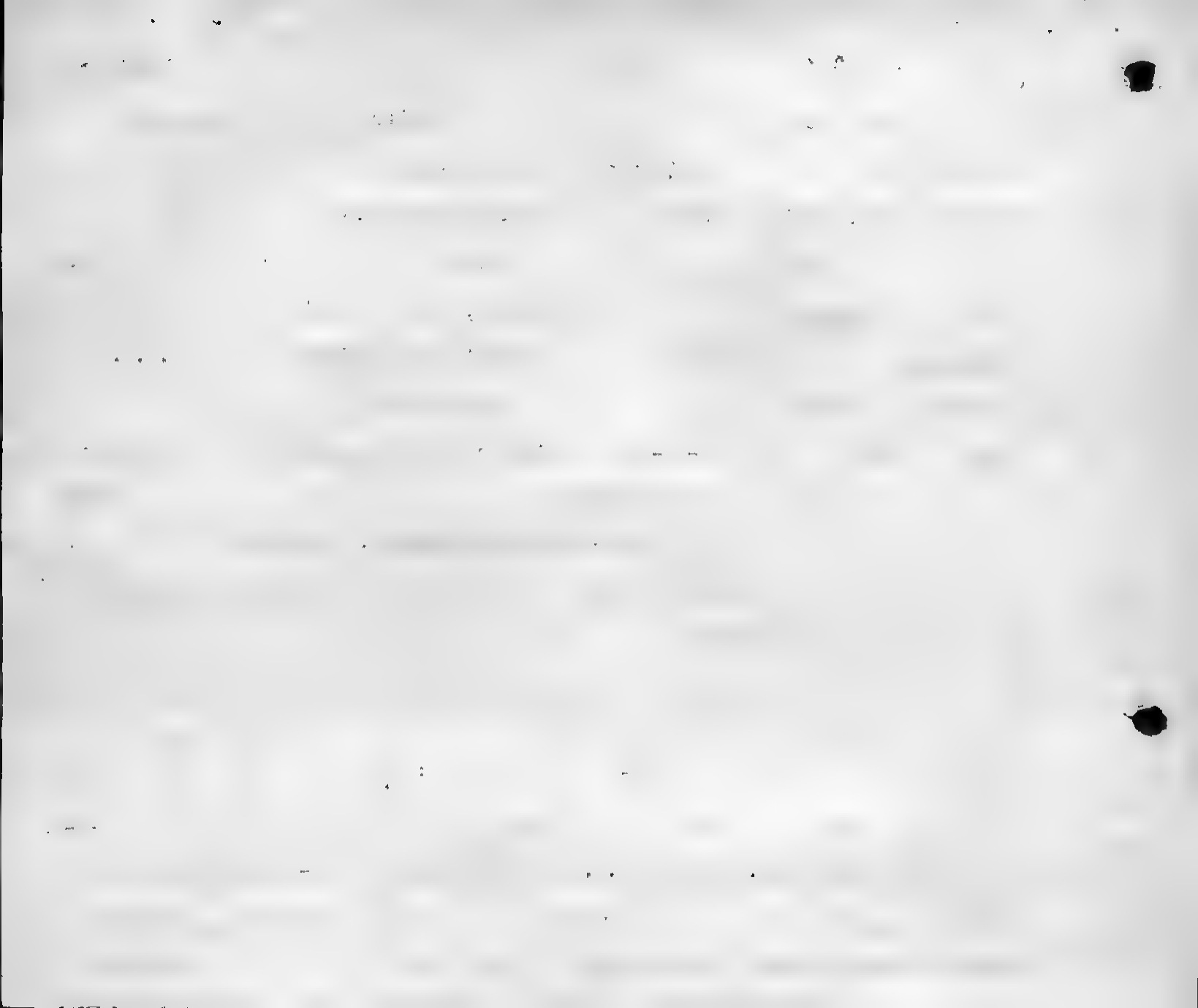
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4032

04026

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 267 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 27 Hazel Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip T Potter		4. DATE OF DEATH April 7 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1876	
9. AGE (in years last birthday) 84 years		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Benjamin F Potter		14. MOTHER'S MAIDEN NAME Mary Connelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-05-6084	
17. INFORMANT Clin Rec VAH Baltimore Md - Ft Howard Division		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (b) UPPER GASTRO-INTESTINAL BLEEDING, UNDETERMINED ETIOLOGY (a), stating the underlying cause last, (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH DECOMPENSATION/ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CEREBRAL ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 3 WEEKS (UNKNOWN)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I (this hospital) attended the deceased from July 14 1960 to April 7 1961 , that I (we) last saw the deceased alive on April 7 1961 , and that death occurred at 6:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Arthur T. Faulk		22b. DATE SIGNED 4-8-61	
22c. PHYSICIAN'S NAME (Type) Arthur T. Faulk M.D.		22d. ADDRESS VAH Baltimore Md - Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Howard H Hubbard		25a. REC'D BY REGISTRAR APR 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 11/59

1
4033
M
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04027

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Lytlldays	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 110 Parkin Street	
3. NAME OF DECEASED (Type or print) First Catherine Middle Overby Last Powell		4. DATE OF DEATH Month April Day 13 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1911
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Bunch		14. MOTHER'S MAIDEN NAME Mary E. Beck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 692.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Retroperoneal Abscess (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a), (b), and (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 4, 1961 to April 13, 1961 that (I) (we) last saw the deceased alive on April 13, 1961 and that death occurred at 3:45 A. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 4-13-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/61	
23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		23d. LOCATION (City, town, or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.		25a. REC'D BY REGISTRAR DATE APR 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 Cedarwood Road				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 5 Cedarwood Road							
3. NAME OF DECEASED (Type or print) Jessie X. Pugh				4. DATE OF DEATH April 18, 1961				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 15, 1883 9. AGE (in years last birthday) 77 yrs. 10. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 11. CITIZEN OF WHAT COUNTRY? U.S.A.			
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Retired Homemaker 13. FATHER'S NAME Charles C. Spies 14. MOTHER'S MAIDEN NAME Sophie E ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Miss Irma E. Pugh-5 Cedarwood Road # 28				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia (b) Carcinoma of urinary bladder (c) 3 days 10 mo. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 7/29, 1960, to 4/18, 1961, that (I) (we) last saw the deceased alive on 4/11, 1961, and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert A. Reiter 22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) Robert A. Reiter M.D. 22d. ADDRESS 3408 Windsor Ave				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-21-61 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d. LOCATION (City, town or county) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE APR 20 '61											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> c. LENGTH OF STAY IN lb <u>7</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5331 Hogwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> d. STREET ADDRESS <u>5331 Hogwood Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest</u> First <u>Michael</u> Middle <u>Reitz</u> Last 5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 9, 1899</u> 9. AGE (in years last birthday) <u>61</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u> 11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		4. DATE OF DEATH <u>April 5/61</u> 19 <u>19</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME <u>Frederick Reitz</u> 14. MOTHER'S MAIDEN NAME <u>Helena</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO <u>4201</u> 17. INFORMANT <u> Evelyn Reitz - 5331 Hogwood Rd.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.1 DUE TO (b) <u>3 hours</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> 19 <u>60</u> to <u>4/5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>61</u> , and that death occurred on <u>1/34</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wesley J. Miller</u> 22b. DATE SIGNED <u>25/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Wesley J. Miller</u> 22d. ADDRESS <u>1047 Torbless Drive, Baltimore 28, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Karraine</u> 23d. LOCATION (City, town, or county) <u>Balto. Md</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley J. Miller</u> 25a. REC'D BY REGISTRAR <u>APR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

MEDICAL CERTIFICATION

(I)

(M)

(8)

4035

04029



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04030**

4036

1. PLACE OF DEATH a. COUNTY Baltimore County DUNDALK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b LIFE		X BALTIMORE - Dundalk	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		d. STREET ADDRESS 7546 LIVES LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First TERRY Middle JOSEPH. Last RICHARDSON		4. DATE OF DEATH Month 4 - Day 18 Year 1961	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-56
9. AGE (In years last birthday) 4 yrs		IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS Hours 2 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
			12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WILLIAM H. RICHARDSON.		14. MOTHER'S MAIDEN NAME JULIA J. MURRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT W. H. RICHARDSON, 7546 LIVES LANE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar PNEUMONIA 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Cerebral Palsy DUE TO (c) INANITION		INTERVAL BETWEEN ONSET AND DEATH 4 days SINCE BIRTH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1957 to April 18, 1961 , that I last saw the deceased alive on April 18, 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris A. Jacobs		ADDRESS (Street, city or town, state) 1010 NORTH Point Rd	
PHYSICIAN'S NAME (Type) MORRIS A. JACOBS		DATE SIGNED 4/18/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-19-61	22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS
22d. LOCATION (City, town, or county) BALTO.		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Dabrowski 1005 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE APR 20 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and completely filled in by the funeral director. After page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4037

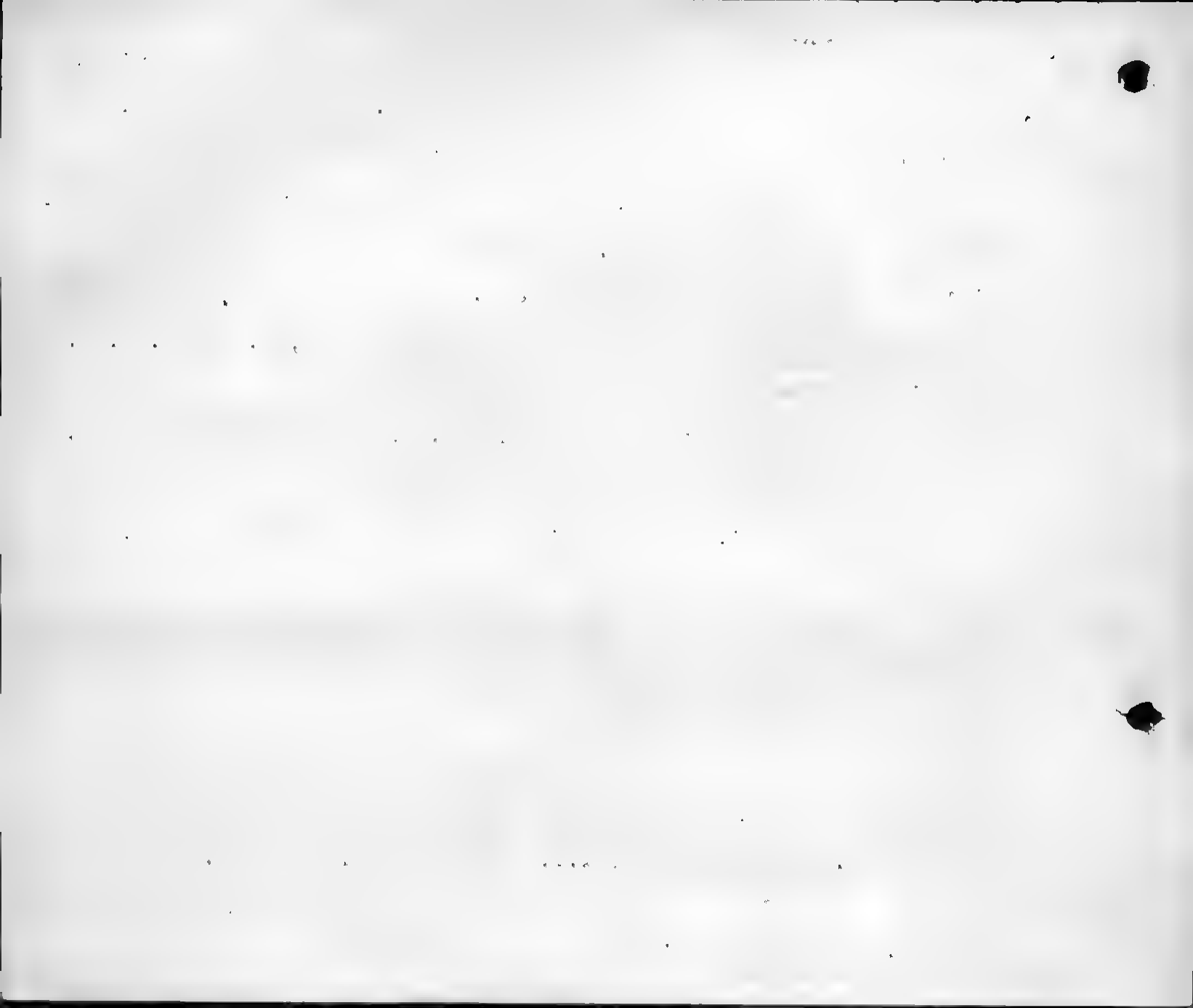
04031

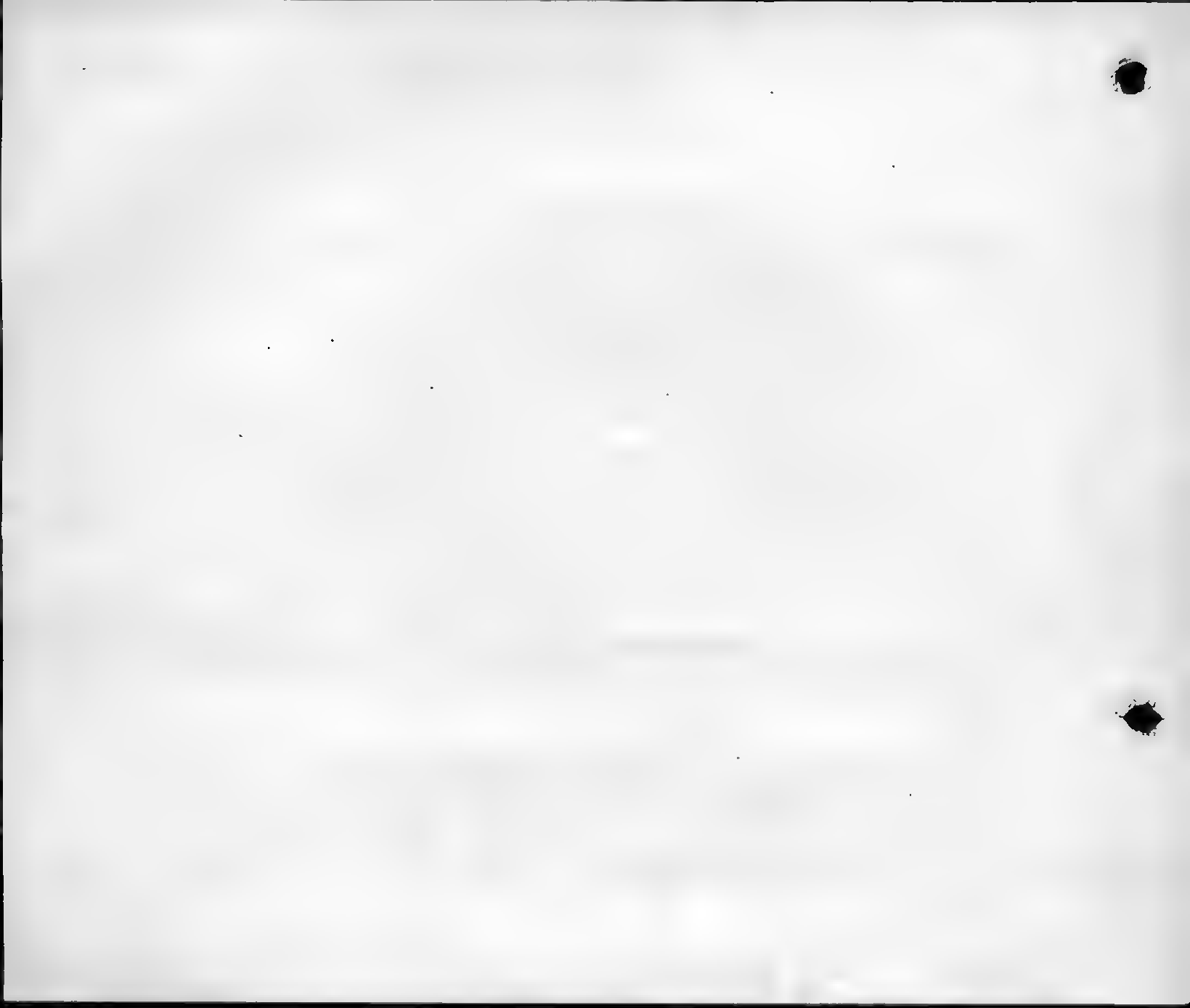
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 139 Elizabeth Avenue		d. STREET ADDRESS 139 Elizabeth Avenue	
3. NAME OF DECEASED (Type or print) First Naomi Middle A. Last Rinick		4. DATE OF DEATH Month April Day 5 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Schuchman		14. MOTHER'S MAIDEN NAME Amanda Biedel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, (if yes give war or dates of service)) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Garnet A. Rinick		Address 139 Elizabeth Ave. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion acute 420.1 DUE TO Coronary Insufficiency due to Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 2 mos (c)			INTERVAL BETWEEN ONSET AND DEATH 2 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Urinary Tract Infection 8 yrs (b) Chronic Diarrhea (c) Post-Sigmoid Ectomy			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 22, 1954 to April 5, 1961 , that (I) (we) last saw the deceased alive on March 31, 1961 , and that death occurred on April 5, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE C. Arthur Rossberg, M.D.		22b. ADDRESS 2436 Washington Blvd.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/8/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR APR 10 1961	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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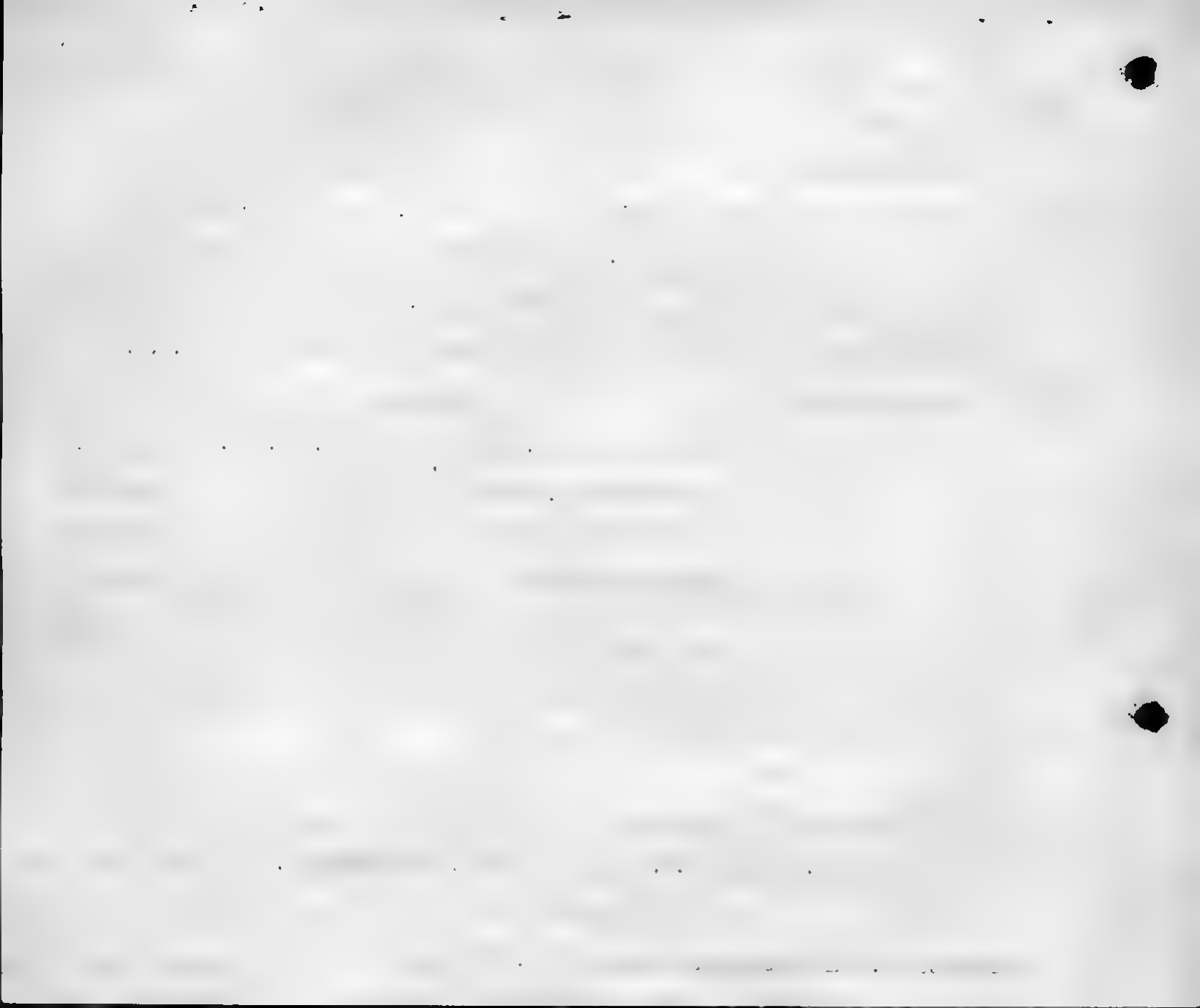


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4033 CERTIFICATE OF DEATH 04033											
Item 9 Film G285 1/12/61											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b. 37 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1103 W. Mulberry Street							
3. NAME OF DECEASED (Type or print) JOHN H. ROBINSON				4. DATE OF DEATH Month April Day 9 Year 1961				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1888		9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator				10b. KIND OF BUSINESS OR INDUSTRY Tower Building				11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Robinson				14. MOTHER'S MAIDEN NAME Anna Allen				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 218-22-9241				17. INFORMANT Clint. Records. VAH, Balto. Md. Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RECENT DUE TO Conditions, if gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA GALL BLADDER DUE TO (c) JAUNDICE DUE TO #2											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from March 3, 1961 to April 9, 1961 , that (X) (we) last saw the deceased alive on April 9, 1961 , and that death occurred at 11:15P from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 4/10/61			
22c. PHYSICIAN'S NAME (Type or print) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VAH, BALTIMORE, MD. - FT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-13-1961				23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				ADDRESS Funeral Home 1808 N. Monroe St. Balto 17, Md.				25a. REC'D BY REGISTRAR APR 12 '61			
								25b. REGISTRAR'S SIGNATURE Charles L. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

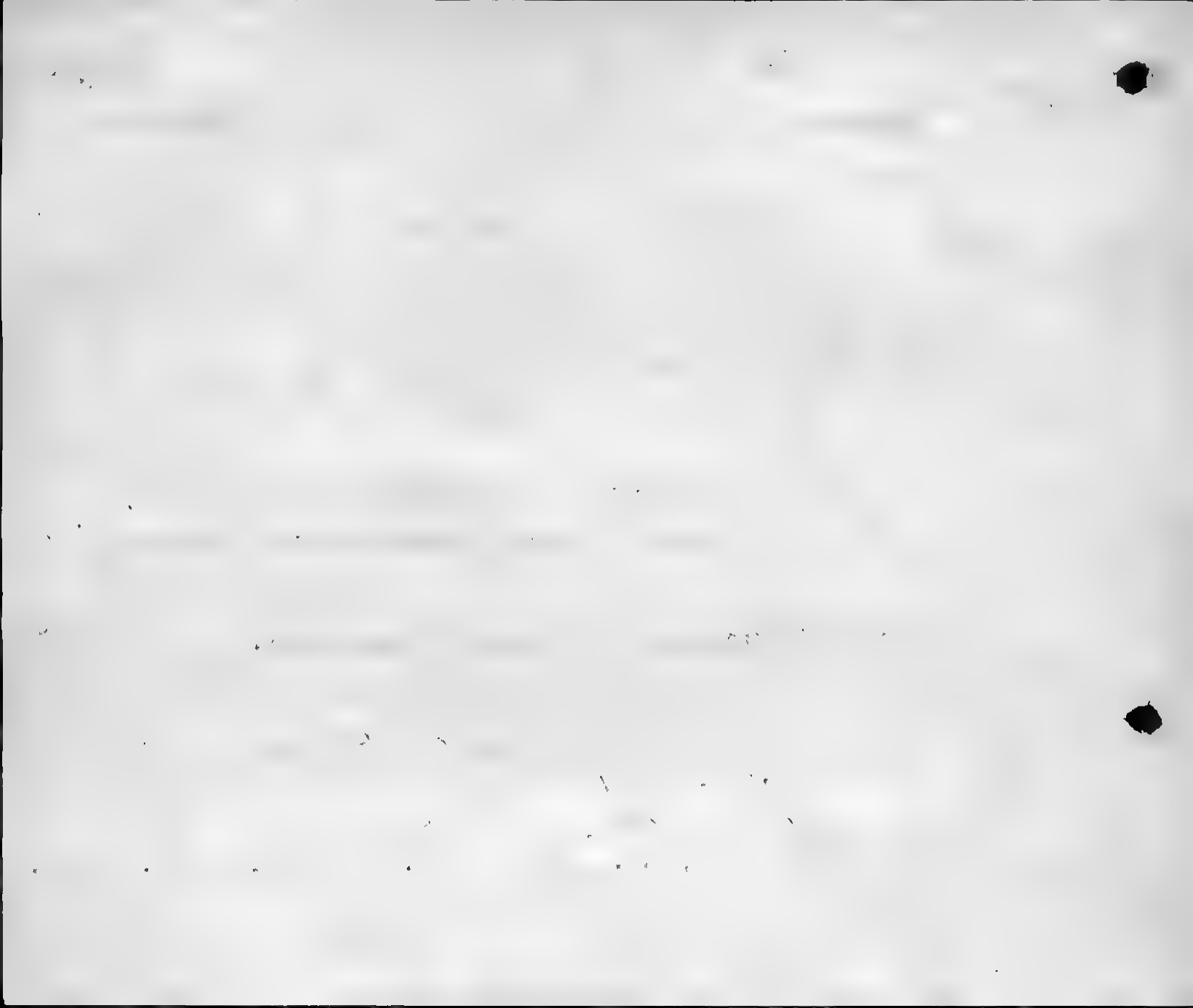
04034

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (For cities of corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1133 Glendale Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if not within residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1133 Glendale Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Marie C. Robinson</u>		4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>19</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 18, 1930</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Schuchle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hartman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service)		16. SOCIAL SECURITY NO. <u>4101</u>	
17. INFORMANT <u>Clifton W. Robinson Sr</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. PATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rheumatic Heart Disease with mitral stenosis</u> (c), stating the underlying cause last, DUE TO <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous cell carcinoma of the cervix of the uterus.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 26, 1947</u> to <u>April 8, 1947</u> that (I) (we) last saw the deceased alive on <u>April 8, 1947</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred Cole</u>		22b. DATE SIGNED <u>APR 12 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred Cole, M.D.</u>		22d. ADDRESS <u>136 S. Hilton St., Balto. 29, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/12/47</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Edmondson Ave</u>		23d. LOCATION (City, town or county) (State) <u>Balto. 29. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter 4101 Edmondson Ave</u>		25a. REC'D BY REGISTRAR DATE <u>APR 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Walter S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

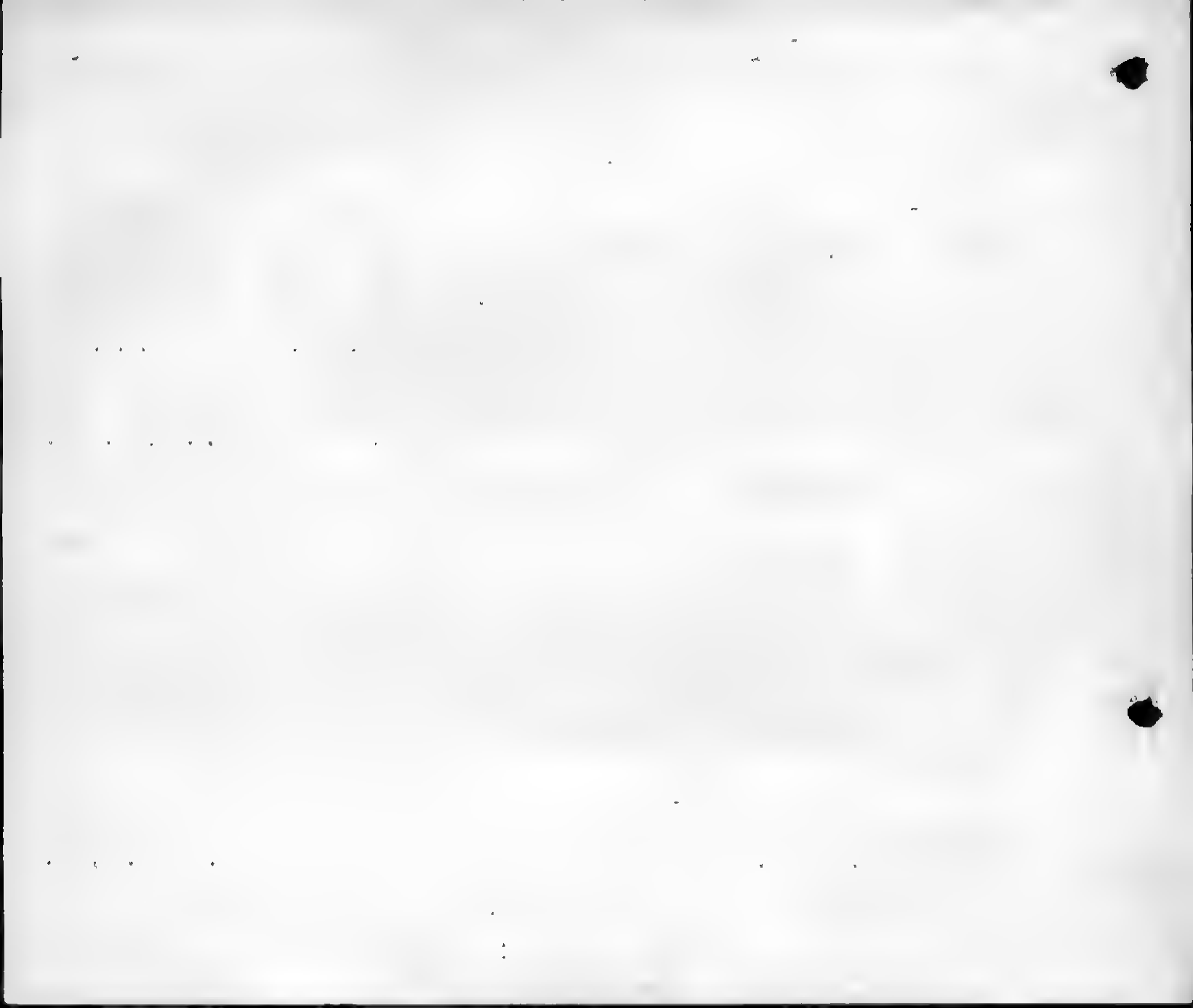


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04035

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Randallstown		c. LENGTH OF STAY IN TB 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chapel Hill Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mrs. Ida Middle B. W. Last Roe		4. DATE OF DEATH Month April Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1866
9. AGE (In years last birthday) 94 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Caroline Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Williams		14. MOTHER'S MAIDEN NAME Annie Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Irene Roe		Address 6408 Walnut St. Balto. 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease DUE TO (b) Acute bacterial pneumonia DUE TO (c) Generalized Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 yrs 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 16, 1957 to April 12, 1961 , that (I) (we) last saw the deceased alive on April 12, 1961 , and that death occurred at 8 AM , from the causes and on the date stated above.			
22a. SIGNATURE Earl L. Chambers		22b. DATE SIGNED 4/13/61	
22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Chambers		22d. ADDRESS 4108 Liberty Heights Ave. Balto. 7, Md.	
23a. BURIAL, CREMATON OR REMOVAL (Specify) Burial	23b. DATE THEREOF 4/15/1961	23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.	23d. LOCATION (City, town, or county) (State) Easton, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Loring Myers		25a. REC'D BY REGISTRAR APR 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4042

04036

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9 Gerard Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> d. STREET ADDRESS <u>9 Gerard Avenue</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur I. Ropka</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 23, 1887</u> 9. AGE (In years last birthday) <u>73</u> yrs IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>19</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Transit Co. Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ropka</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>154X</u> 17. INFORMANT <u>Mrs. Arthur I. Ropka-9 Gerard Avenue-Timonium</u> Address <u>9 Gerard Avenue-Timonium</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RECTUM, METASTATIC</u> DUE TO (b) <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>154X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>CARCINOMA OF PROSTATE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2060 YORK RD, TIMONIUM, MD.</u>		20d. (City or town) <u>Timonium</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 11, 1961</u> to <u>APRIL 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>APR 11, 1961</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William A. Pillsbury</u>		22b. DATE SIGNED <u>4-17-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		22d. ADDRESS <u>2060 YORK RD, TIMONIUM, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 19, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Gardens</u>		23d. LOCATION (City, town or county) <u>Maryland</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Pillsbury</u>		25a. REC'D BY REGISTRAR <u>William A. Pillsbury</u> 25b. REGISTRAR'S SIGNATURE <u>William A. Pillsbury</u> DATE <u>APR 18 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4043

CERTIFICATE OF DEATH

Reg. Dist. No. 04037

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Towson		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 Malvern Ave		e. STREET ADDRESS 1700 Malvern Ave.	
3. NAME OF DECEASED (Type or print) FRANK JAMES ROWE		4. DATE OF DEATH April 4 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1890
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurateur		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Bellfont, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John C. Rowe		14. MOTHER'S MAIDEN NAME Martha Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 216-32-4976	
INFORMANT Margaret Peyton Rowe		Address 700 Malvern Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			INTERVAL BETWEEN ONSET AND DEATH 24 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-20, 1960 , to 4-4, 1961 , that I last saw the deceased alive on 4/3, 1961 , and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1125 St Paul St Baltimore, Maryland DATE SIGNED 4/6/61 ACTUAL SIGNATURE H. D. Franklin PHYSICIAN'S NAME (Type) H. D. Franklin 1125 St Paul St Baltimore, Maryland DATE SIGNED 4/6/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-7-61	22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEMETERY	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cvec		ADDRESS 1211 Chesaco Ave.	
24a. REC'D BY REGISTRAR APR 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

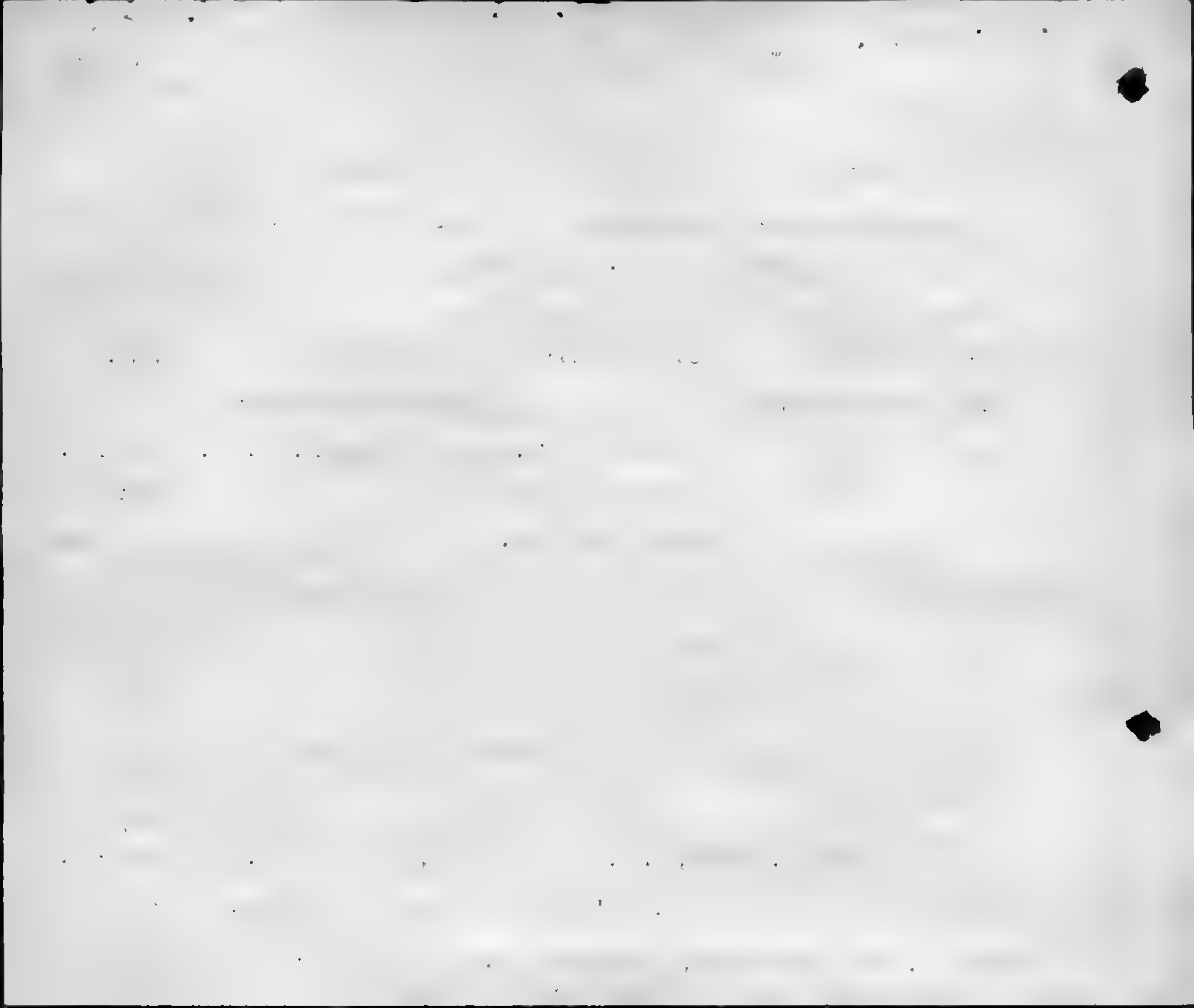
4044

04038

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY (In days) <u>7 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4031 Shannon Drive</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE A. RUBY</u>		4. DATE OF DEATH Last Month Day Year <u>April 12 19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1922</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Factory</u>	
13. FATHER'S NAME <u>Vincent McClellan Ruby</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bennetta Cavanagh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>214-18-9594</u>	
17. INFORMANT Address _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYELOMA</u> (b) <u>AZOTEMIA DUE TO A.</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVA. BETWEEN SET AND DEATH <u>4 YEARS</u> UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 5</u> <u>1961</u> , to <u>April 12</u> <u>1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 5</u> <u>1961</u> , and that death occurred at <u>5:40 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Crahan</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED <u>4/12/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M. D.</u>		22d. ADDRESS <u>VAH, Baltimore, Md. Ft. Howard Div.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>APR 14 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>5305 Harford Rd. Baltimore, Maryland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. Page 2 should be filed with the attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

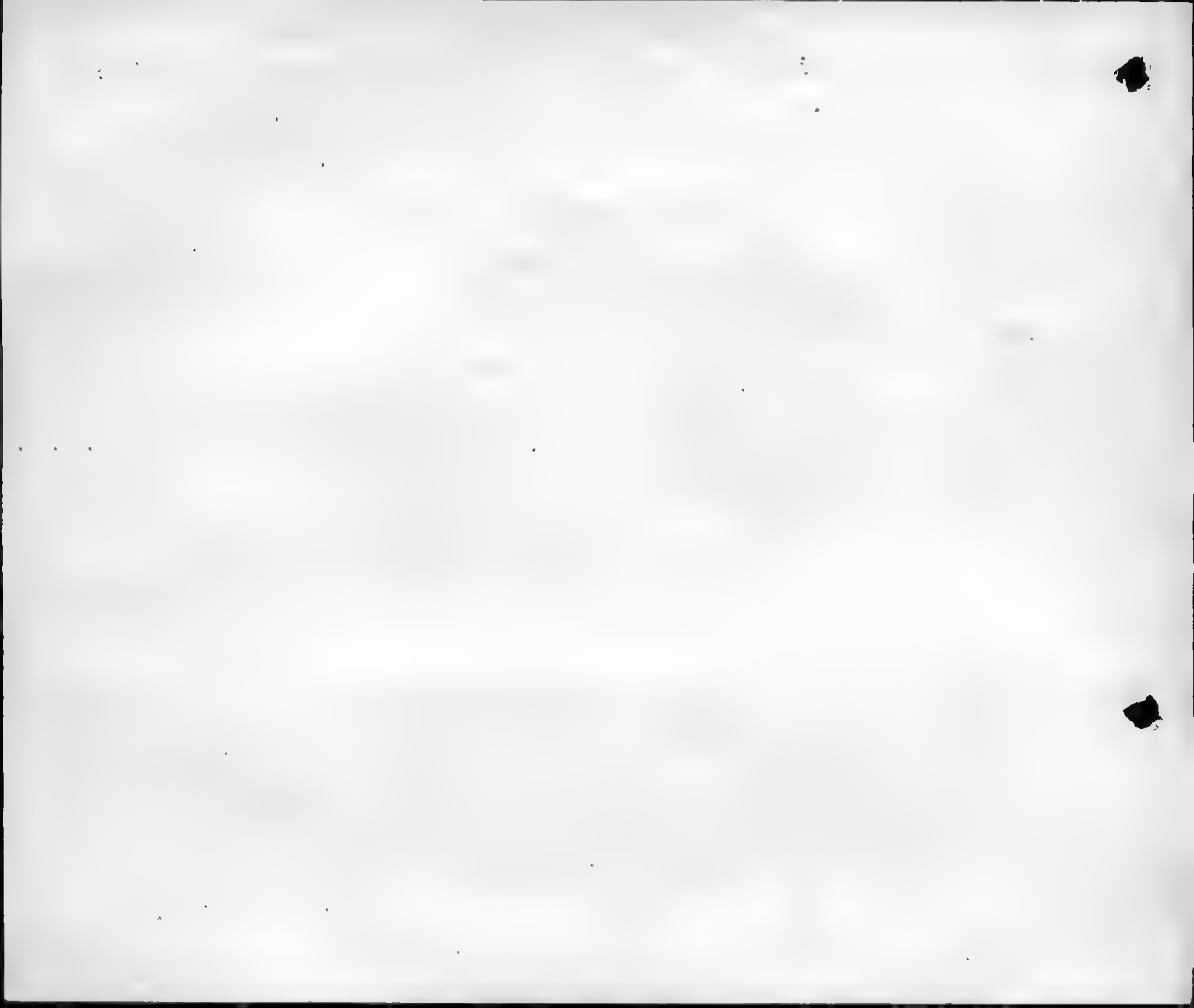
VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit.

Page 1

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0445
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04039

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Washington, D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph's Nursing Home		d. STREET ADDRESS 2311 Connecticut Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Maria Rucinska		4. DATE OF DEATH Month Day Year April 11, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Joseph Harabianko		14. MOTHER'S MAIDEN NAME Sophia Zukowska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Washington 8, D. C. Mr. Joseph Rucinski 2311 Connecticut Ave. N. W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) Generalized Arteriosclerosis with (c) gangrene right leg. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Impending gangrene and gangrene of right leg of 4 wks.		INTERVAL BETWEEN ONSET AND DEATH 4/10/61 - 4/12/61	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/11/61 to 4/12/61 1961, that (I) (was) last saw the deceased alive on 4/9/61 1961, and that death occurred at 8 P. M. from the causes and on the date stated above			
22a. SIGNATURE B. Martin Middleton		22b. DATE SIGNED 4/12/61	
22c. PHYSICIAN'S NAME (Type) B. Martin Middleton M. D.		22d. ADDRESS 614 Medical Dets Balto 1, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/61	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
C. A. S. T. Hospital Home Catonsville, Md.		DATE APR 19 '61	



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TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4046

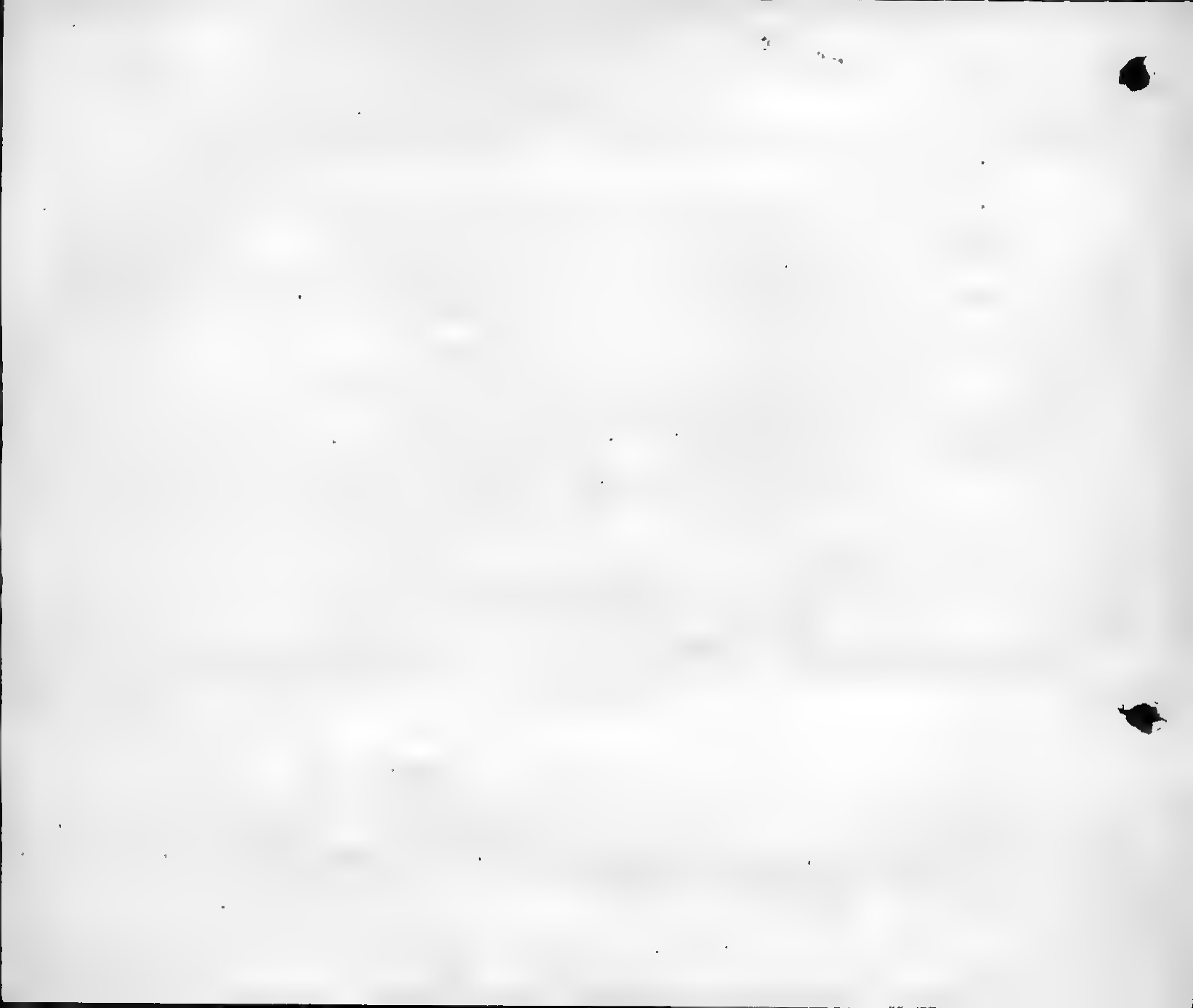
CERTIFICATE OF DEATH

Item 9 Film 4203 4/23/61 iwk

04040

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr9mth9dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 7487 Frederick Avenue * Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 7487 Frederick Avenue		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Albert Middle Noah Last Ruff			4. DATE OF DEATH Month April Day 17 Year 19 61		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1905		9. AGE (In years last birthday) 55 yrs.
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) plumber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frederick Ruff			14. MOTHER'S MAIDEN NAME Hedy Rallings		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 212-16-9961		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malignant lesion of liver 5811 DUE TO Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic alcoholism DUE TO (c) Chronic alcoholism					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 3, 1961 to April 17, 1961 , that (I) (we) last saw the deceased alive on April 17, 1961 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Stella Wachslar		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-19-1961		23c. NAME OF CEMETERY OR CREMATORY Salem Lutheran	
23d. LOCATION (City town or county) (State) Catonsville Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Edw. A. MacKitt Jr.			ADDRESS 301 Frederick Road 28		25a. REC'D BY REGISTRAR DATE APR 20 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Kneass		





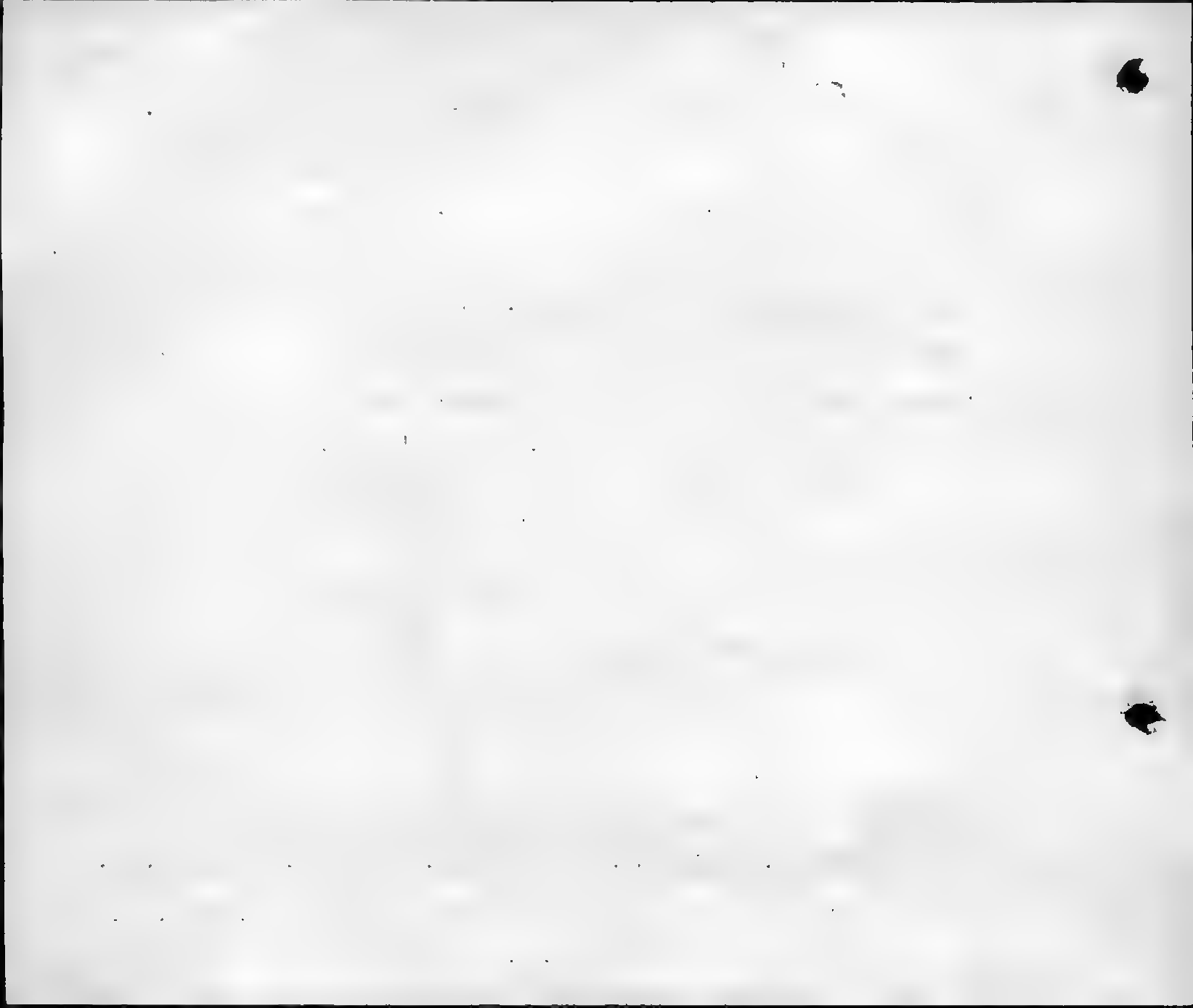
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
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VR A15 (4)
15M 9/59

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4043
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04042

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Brooklyn Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Conv. Home		d. STREET ADDRESS 121 W. Meadow Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Santa Middle Scalie Last		4. DATE OF DEATH Month April Day 24 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Michael Balsame		14. MOTHER'S MAIDEN NAME Frances Scalie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Frances D'Alfonzo		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic C.V. Disease DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 1958 to April 24, 1961 , that (I) (we) last saw the deceased alive on 4/24 1961, and that death occurred at 11 AM , from the causes and on the date stated above			
22a. SIGNATURE Vincent M. Messina		22b. DATE April 26, '61	
22c. PHYSICIAN'S NAME (Type) Vincent M. Messina M.D.		22d. ADDRESS 1403 S. Charles St. Baltimore, Md.	
23a. BURIAL CREMATION, REMOVA (Specify) Burial		23b. DATE THEREOF April 28, 1961	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gence		25a. REC'D BY REGISTRAR 4001 Ritchie Hwy. A. A. STATE MARY 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

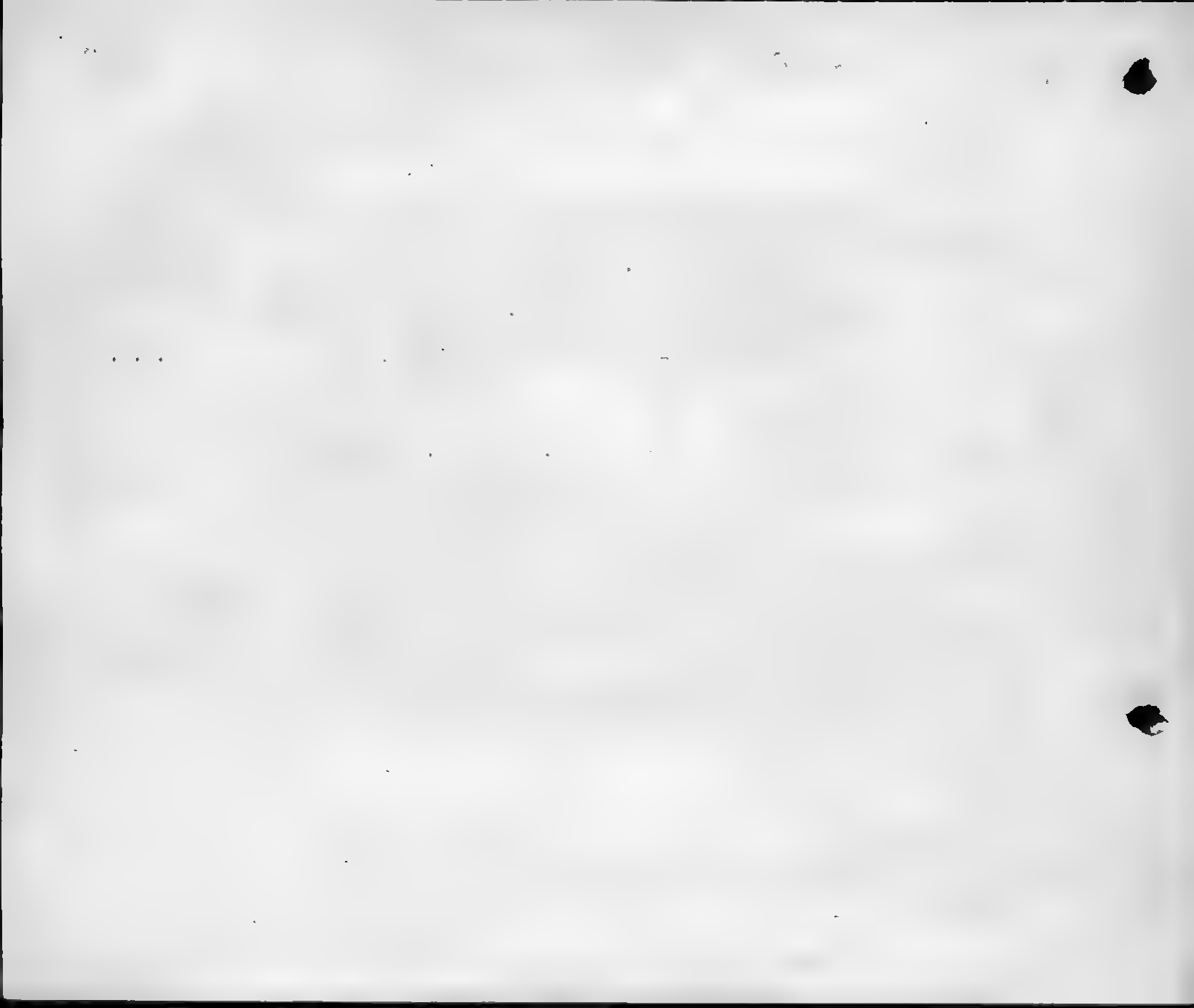
CERTIFICATE OF DEATH

4049

04043

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Lochearn</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3601 Lochearn Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u> d. STREET ADDRESS <u>3601 Lochearn Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George F. Scherer</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Dec. 7, 1875</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>April 21, 1961</u> Month Day Year 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Conrad-Hamp Company</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>August Scherer</u> 14. MOTHER'S MAIDEN NAME <u>Sophia ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>012-03-9565</u> 17. INFORMANT <u>Mr. George M. Scherer</u> Address <u>3601 Lochearn Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>AS&D</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute & Chr. Diverticulitis, Colon</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25, 1959</u> to <u>April 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 20, 1961</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel Bakal</u> 22c. PHYSICIAN NAME (Type) <u>DANIEL BAKAL</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>3600 Lochearn Dr. - 7</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickner & Sons</u>		25a. REC'D BY REGISTRAR <u>North & Penna Aves Balto 17, Md</u> DATE <u>APR 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm J. Lickner</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4050

04044

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Wilson, Maryland</u> c. LENGTH OF STAY IN 1b <u>4 1/2 mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Wilson State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore</u> d. STREET ADDRESS <u>108 N. Prospect Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HERBERT</u> First <u>WILLIAM</u> Middle <u>SCHLIERF</u> Last 4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1961</u>				5. SEX <u>MA</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6 12 1908</u> 9. AGE (In years last birthday) <u>52</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> 11. BIRTHPLACE (State or foreign country) <u>U. A</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. A</u>			
13. FATHER'S NAME <u>CHRISTIAN SCHLIERF</u> 14. MOTHER'S MAIDEN NAME <u>AMANDA (?)</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <u>NO</u> 17. INFORMANT <u>Hospital Records, St. Wilson State Hospital</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>For advanced pulmonary tuberculosis</u> <u>002X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Lung</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>12-6-1960</u> to <u>4-21-1961</u> that (I) (we) last saw the deceased alive on <u>4-21-1961</u> and that death occurred at <u>3:35 PM</u> from the causes and on the date stated above 22a. SIGNATURE <u>Wm. Newcomer</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-1-1961</u> 22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u> 22d. ADDRESS <u>St. Wilson State Hospital, St. Wilson, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-24-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> 23d. LOCATION (City, town, or county) <u>Baltimore - Md</u> (State) _____ 24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Harrison</u> ADDRESS <u>Catonsville - 28-Md</u> 25a. REC'D BY REGISTRAR <u>APR 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4051

04045

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

d. STREET ADDRESS

6700 Parkway Rd. 12

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

Armcast Nursing Home

First

Middle

Last

FRIEDA

H.

SCHNEIDER

5. SEX

Female

White

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Aug. 5, 1883

4. DATE OF DEATH

April 20, 1961 19

9. AGE (In years last birthday)

77 yrs.

IF UNDER 1 YEAR, IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Registered Nurse

Nursing

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Country & State, or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Ludwig Hoffman

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

None

16. SOCIAL SECURITY NO. 17. INFORMANT Address

Viola Collier- 6700 Parkway Rd 12

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

442X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Cerebral Hemorrhage
Hypertensive Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

7 Days

10y

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 17, 1961, to April 20, 1961, that (I) (we) last saw the deceased alive on April 19, 1961, and that death occurred at 9:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Charles O. Howell

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

4/ 22/61

23c. NAME OF CEMETERY OR CREMATORY

Ivy Hill

23d. LOCATION (City, town or county)

Laurel, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Wm Cook-Towson, Inc. 1050 York Rd., Towson

25a. REC'D BY REGISTRAR

DATE APR 24 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

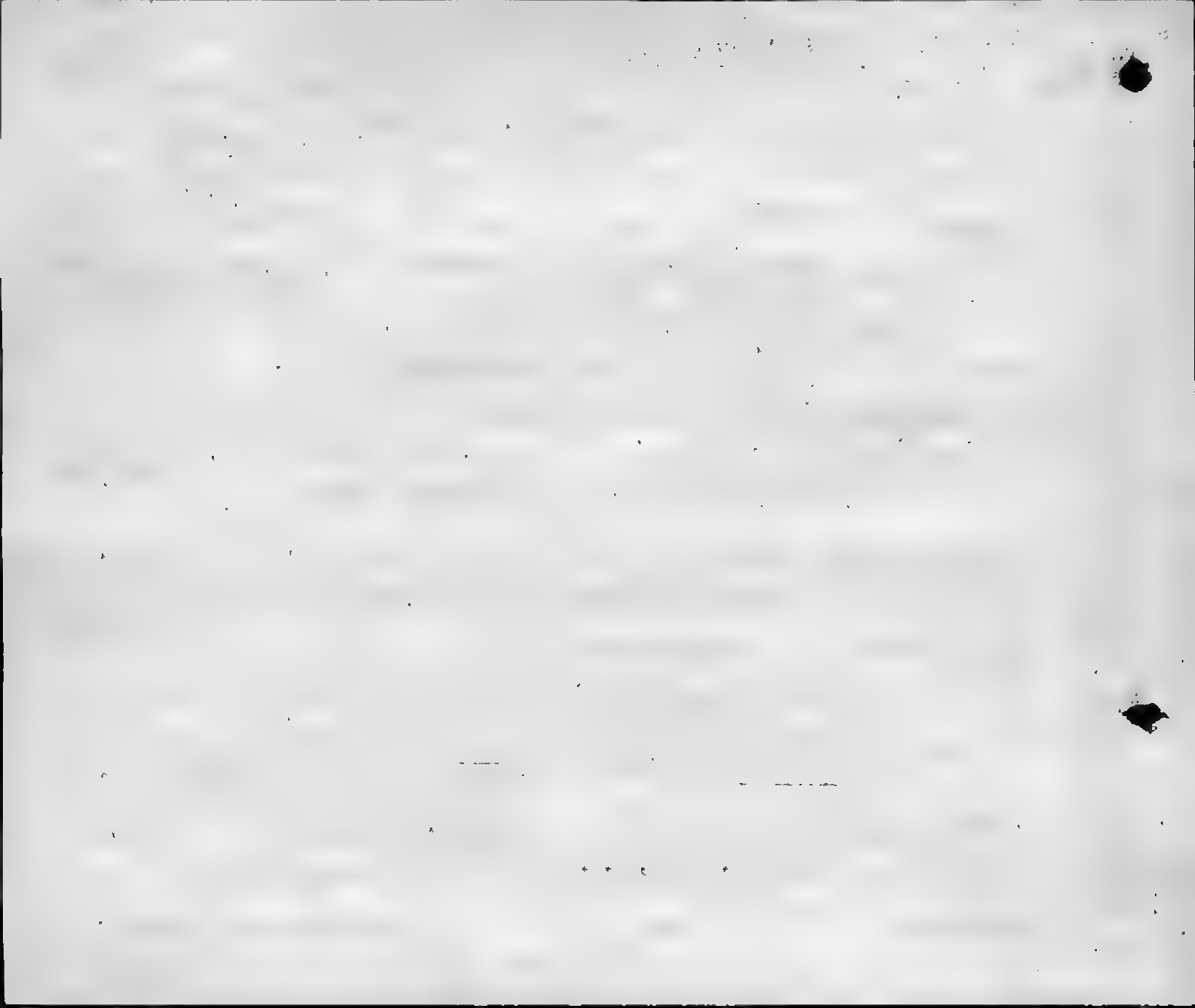
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04046

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore Life c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8921 Grove Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 8921 Grove Road			
3. NAME OF DECEASED (Type or print) JOHN BENJAMIN SCHRENKER				4. DATE OF DEATH Month April Day 27 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-1889	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME John B. Schrenker			
14. MOTHER'S MAIDEN NAME Catherine Braun				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Edward B. Schrenker 3807 Putty Hill Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 722.1 DUE TO (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty M.D. EXAMINER'S NAME (Type) Charles S. Petty, M.D.				DATE SIGNED 4/28/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-1961		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or country) (State) Parkville Md.	
23. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				24a. REC'D BY REGISTRAR MAY 1 1961			
24b. REGISTRAR'S SIGNATURE Arthur L. Howard				DATE			



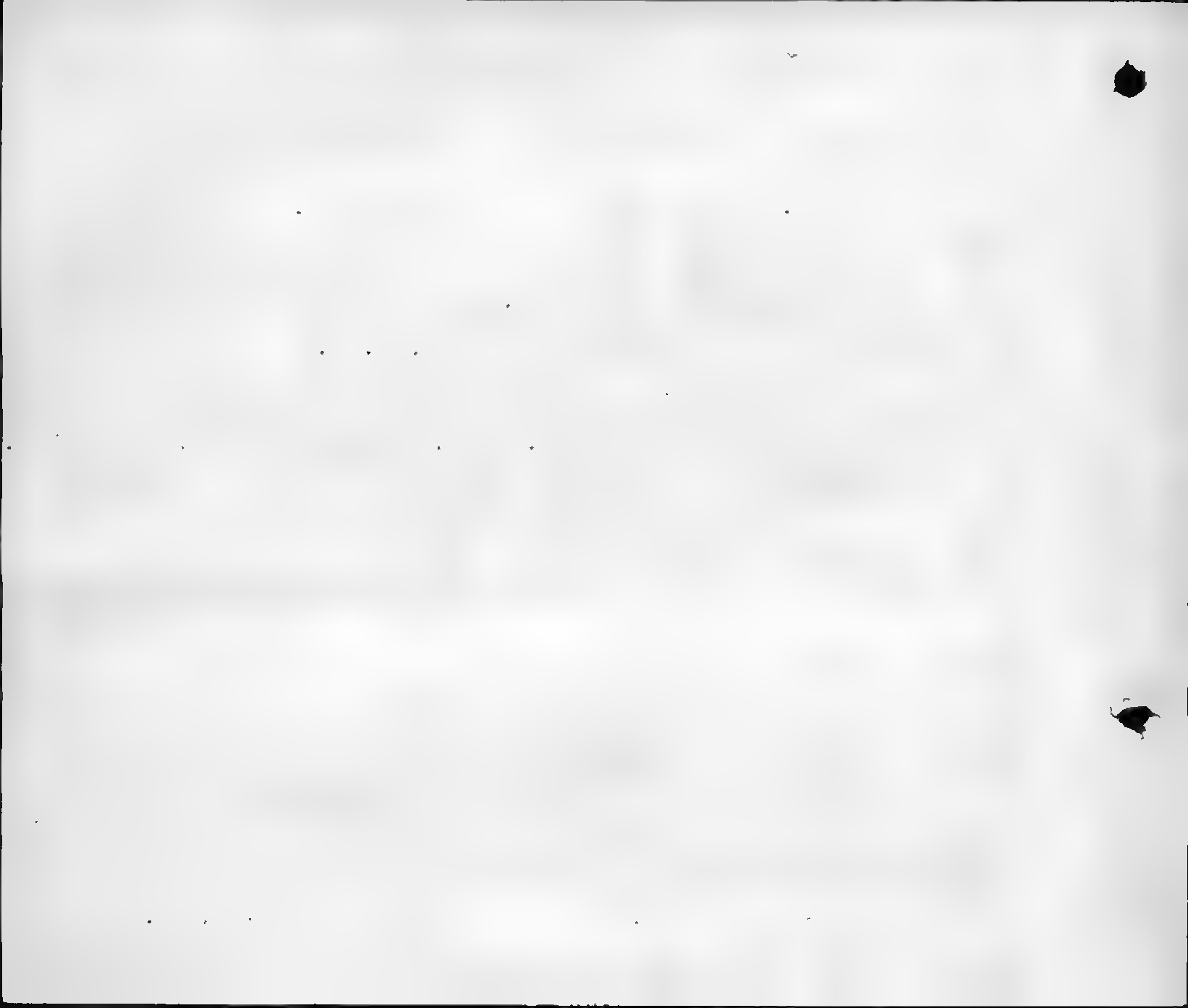
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4053

CERTIFICATE OF DEATH

Reg. Dist. No. 04047

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Rd.</u>				d. STREET ADDRESS <u>Belair Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> <u>Henry</u> <u>Schroeder</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1877</u>		9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Augustus Schroeder</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Roeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mary E. Schroeder</u> Address <u>Belair Rd. Perry Hall Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville, Md</u> DATE SIGNED <u>4-29-61</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Perry Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carolyn Lunnal Stone</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

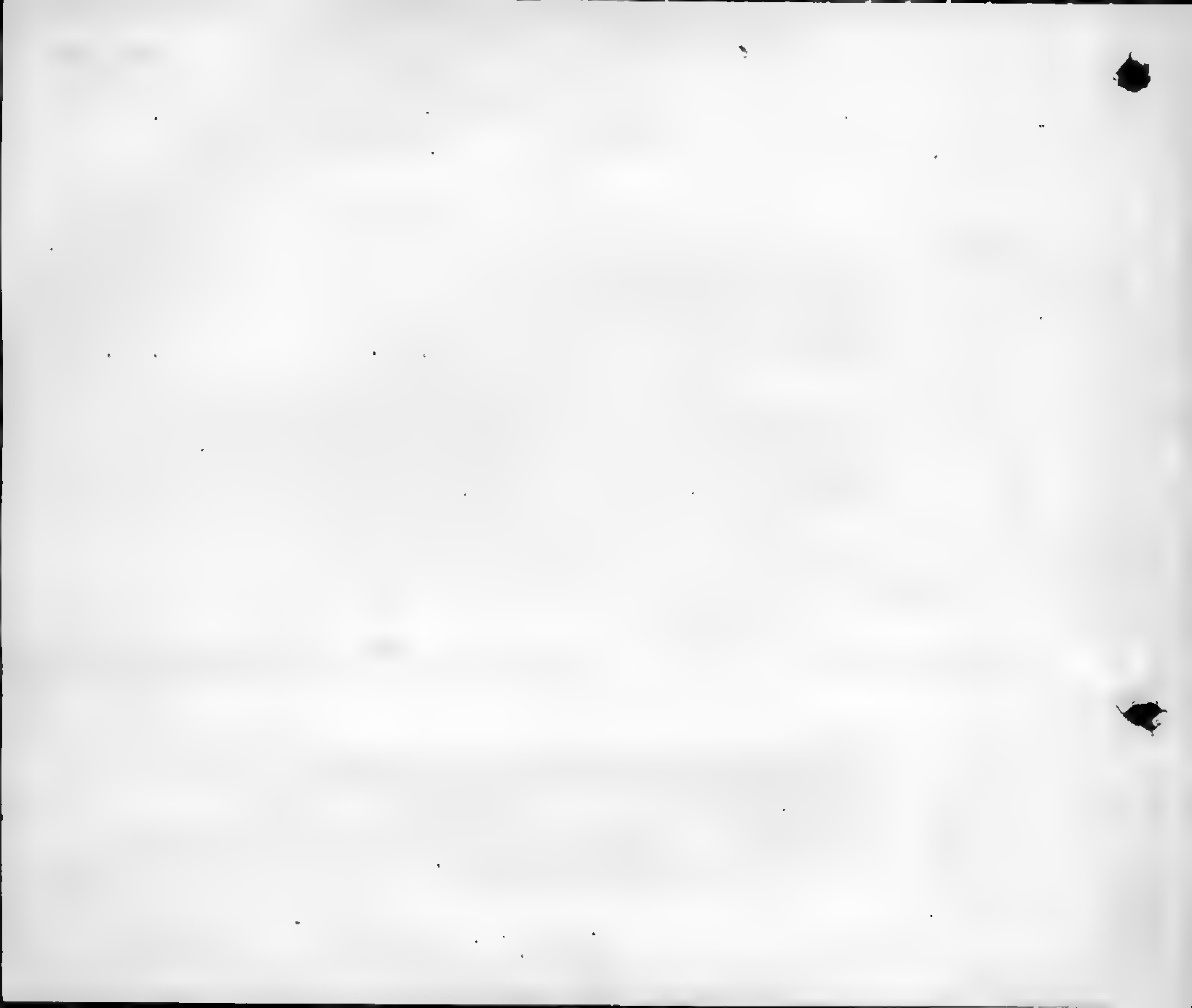


1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4054
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04048

1 PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admittance) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERLEA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERLEA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7505 BELAIR RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARGARET Middle CATHERINE Last SCHULER		4. DATE OF DEATH Month APRIL Day 8 Year 1961	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1906
9 AGE (In years last birthday) 54		10. IF UNDER 1 YEAR Months 3 Days 13 Hours 13 Min. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (State or foreign country) BALTO., MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNST BEHNCKEN		14. MOTHER'S MAIDEN NAME MARIE DENGLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 219-32-0592	
17. INFORMANT DAVID SCHULER		Address 7505 BELAIR RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma - Lungs and Bone 170X DUE TO 1952 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Carcinoma of breast - left 1952 - right 1959 DUE TO 9 yrs (c) Interval between onset and death 3 months			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1952 to April 8, 1961 , that (I) (not) last saw the deceased alive on April 7, 1961 , and that death occurred at 6:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE Charles V. Sevcik M.D.		22b. DATE SIGNED 4/11/61	
22c. PHYSICIAN'S NAME (Type, Charles V. SEVCIK)		22d. ADDRESS 5101 Belair Rd Baltimore, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-12-61	
23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION (City, town, or county) (State) BALTO., MD	
24. FUNERAL DIRECTOR'S SIGNATURE Lillian J. Henry		25a. REC'D BY REGISTRAR APR 14 '61	
ADDRESS 7401 Belair Rd		25b. REGISTRAR'S SIGNATURE Arthur L. Funnell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

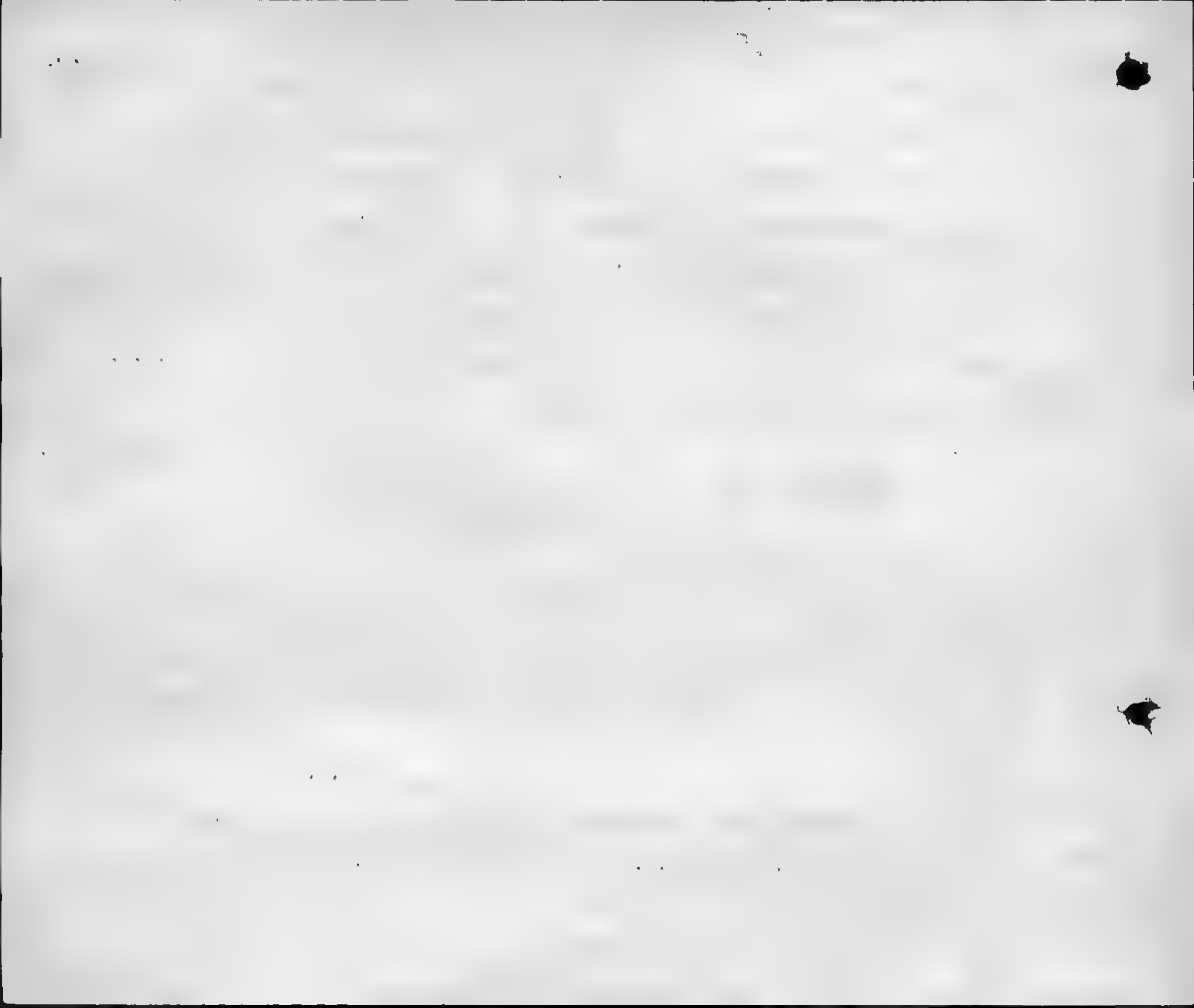
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4055

04049

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Baltimore 30</u> d. STREET ADDRESS <u>1400 Reynolds Street</u> g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christine Helen Shade</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2/10/31</u> 9. AGE (In years last birthday) <u>30</u> IF UNDER 1 YEAR <u>14</u> IF UNDER 24 HRS. <u>19</u> <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dependent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gabriel Shade</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Rosewood Records</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Watkins</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). <u>ASPIRATION PNEUMONITIS</u> (b) <u>SPASTIC DIPLEGIA.</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Owings Mills, Md.</u> 20f. (City or town) <u>Owings Mills, Md.</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>45</u> to <u>4/14</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>4/14</u> 19 <u>61</u> and that death occurred at <u>9:45 a.m.</u> the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest I. Decko</u> 22c. PHYSICIAN'S NAME (Type) <u>Ernest I. Decko, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>4/14/61</u> 22d. ADDRESS <u>Rosewood St. Tr. School, Owings Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-18-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u> 23d. LOCATION (City, town or county) <u>Balto 25</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>McCarthy</u> ADDRESS <u>130 E Fort Ave</u> 25a. REC'D BY REGISTRAR <u>APR 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. Harris</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Pages 3 and 4 should be filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

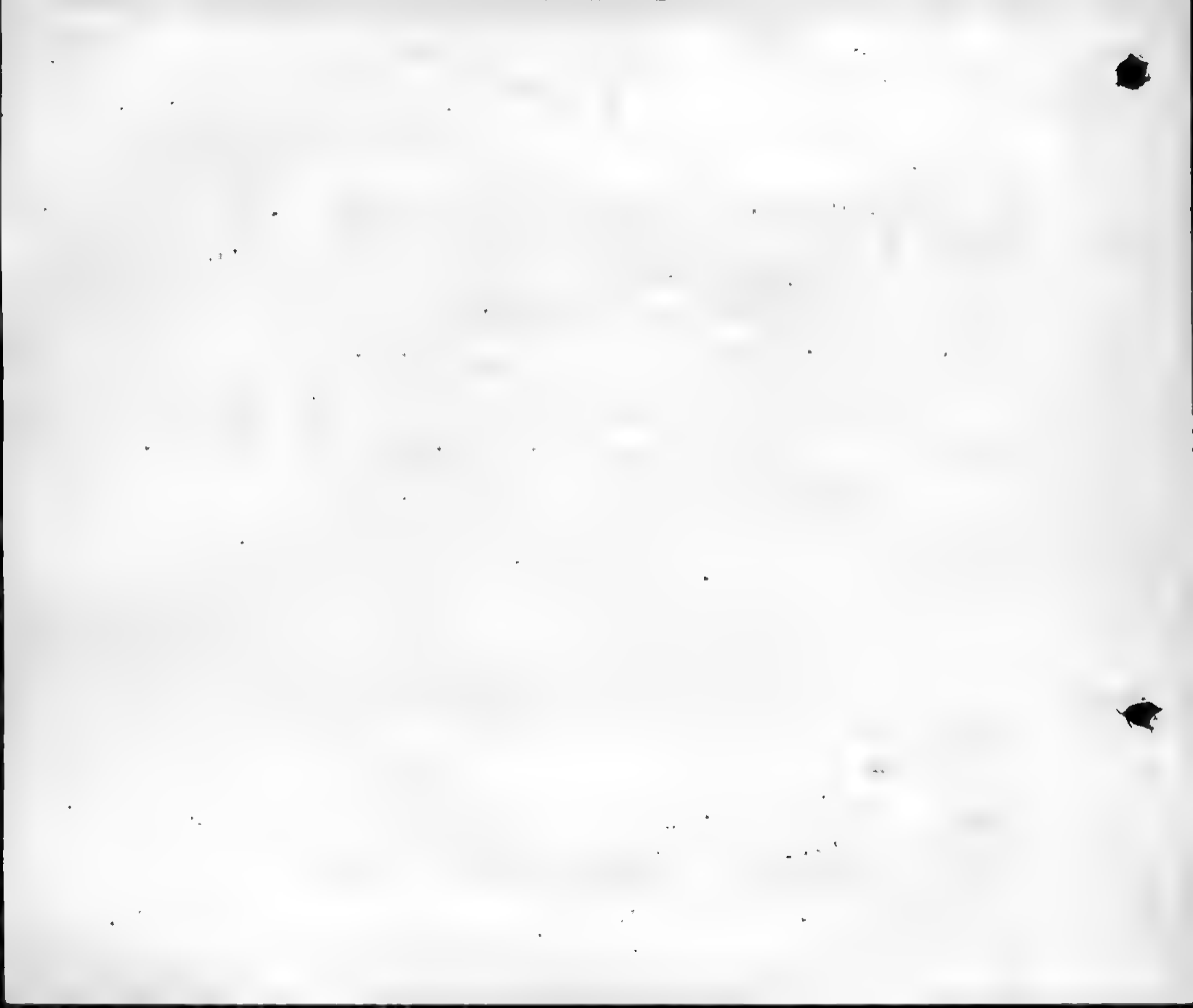
4056

CERTIFICATE OF DEATH

04050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6807 Linden Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Francis Marion Shane Sr		4. DATE OF DEATH Month Apr Day 5 Year 1961	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1880
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Archer Shane	
14. MOTHER'S MAIDEN NAME Mollie Poiner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Mary V. Shane 6807 Linden Ave. (6)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Other selective Cardiovascular Dis (c) Hypertensive Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH Inst Yrs Wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 to 4-5 , 1961, that I last saw the deceased alive on 4-23 , 1961, and that death occurred at 9 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7527 Belair Rd Baltimore, Md DATE SIGNED 4-5-61			
ACTUAL SIGNATURE John C. Hyle		M.D. 7527 Belair Rd	
PHYSICIAN'S NAME (Type) JOHN C. HYLE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-8-1961	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wasson Funeral Home		24a. REC'D BY REGISTRAR DATE APR 7 '61	
ADDRESS 7401 Belair Rd		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing in pencil "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4057

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04051

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		d. STREET ADDRESS <u>Freeland Rd. 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Freeland Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Wilbur Shelley</u>		4. DATE OF DEATH <u>April 7 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joshua M. Shelley</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca J. Hackett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. John S. Swanger, Freeland Md.</u>		Address <u>Freeland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>743X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>G. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>P. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/7/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 10, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Fortenstein, New Freedom, Pa.</u>		24. REC'D BY REGISTRAR <u>—</u> DATE <u>APR 10 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>			



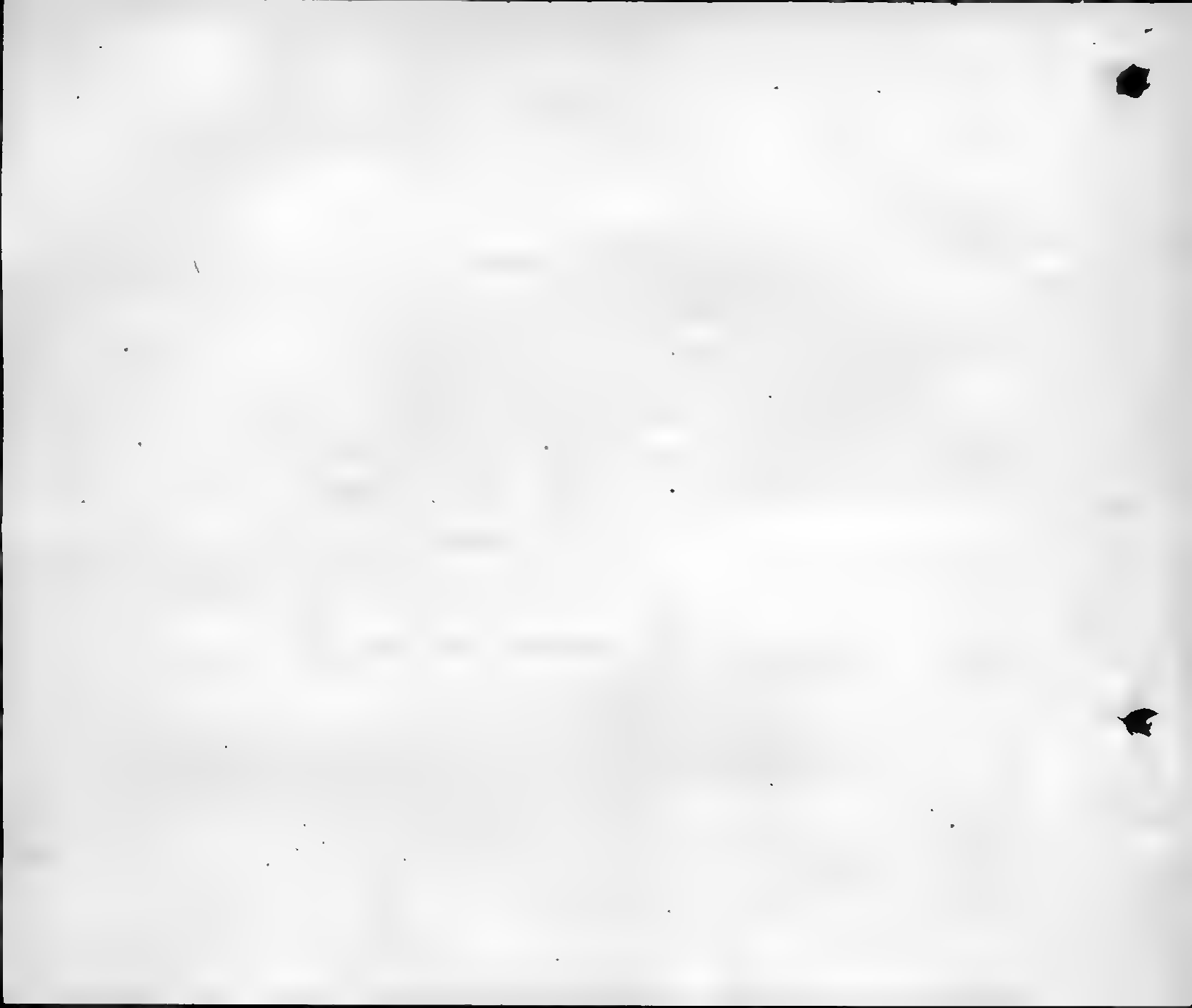
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04052

4058

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before adm-ss on) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 3 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
				d. STREET ADDRESS 412 Murdock Rd			
3. NAME OF DECEASED (Type or print) First Elias Middle John Last Shepperd				4. DATE OF DEATH Month 4 Day 29 Year 1961			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-1883	
9 AGE (in years last birthday) 78 yrs		IF UNDER 1 YEAR Months 4 Days 29 Hours 19 Min.		IF UNDER 24 HRS Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Penn. Rail Road		11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.A							
13 FATHER'S NAME John Shepperd				14. MOTHER'S MAIDEN NAME Ida Bacon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO -		17. INFORMANT A. John Geyer Address 330 Regester Ave. #12	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic Cardio Vascular Disease DUE TO Arteriosclerosis & Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ (c) _____							
INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m. 19 p m				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21 I certify that (I) (his hospital) attended the deceased from Jan 20, 1959 to April 29, 1961 , that (I) (we) last saw the deceased alive on April 27, 1961 , and that death occurred at 1:20 P.M. from the causes and on the date stated above							
22a. SIGNATURE Laurence C. Post				22b. DATE SIGNED 4/28/61			
22c. PHYSICIAN'S NAME (Type) LAURENCE C. Post				22d. ADDRESS 6705 York Rd. Baltimore 12 Md			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-29-61		23c. NAME OF CEMETERY OR CREMATORY St. James My Ladys Manor		23d. LOCATION (City, town, or county) (State) Monkton, Md	
24 FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Serviced Towson 4, Md				25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

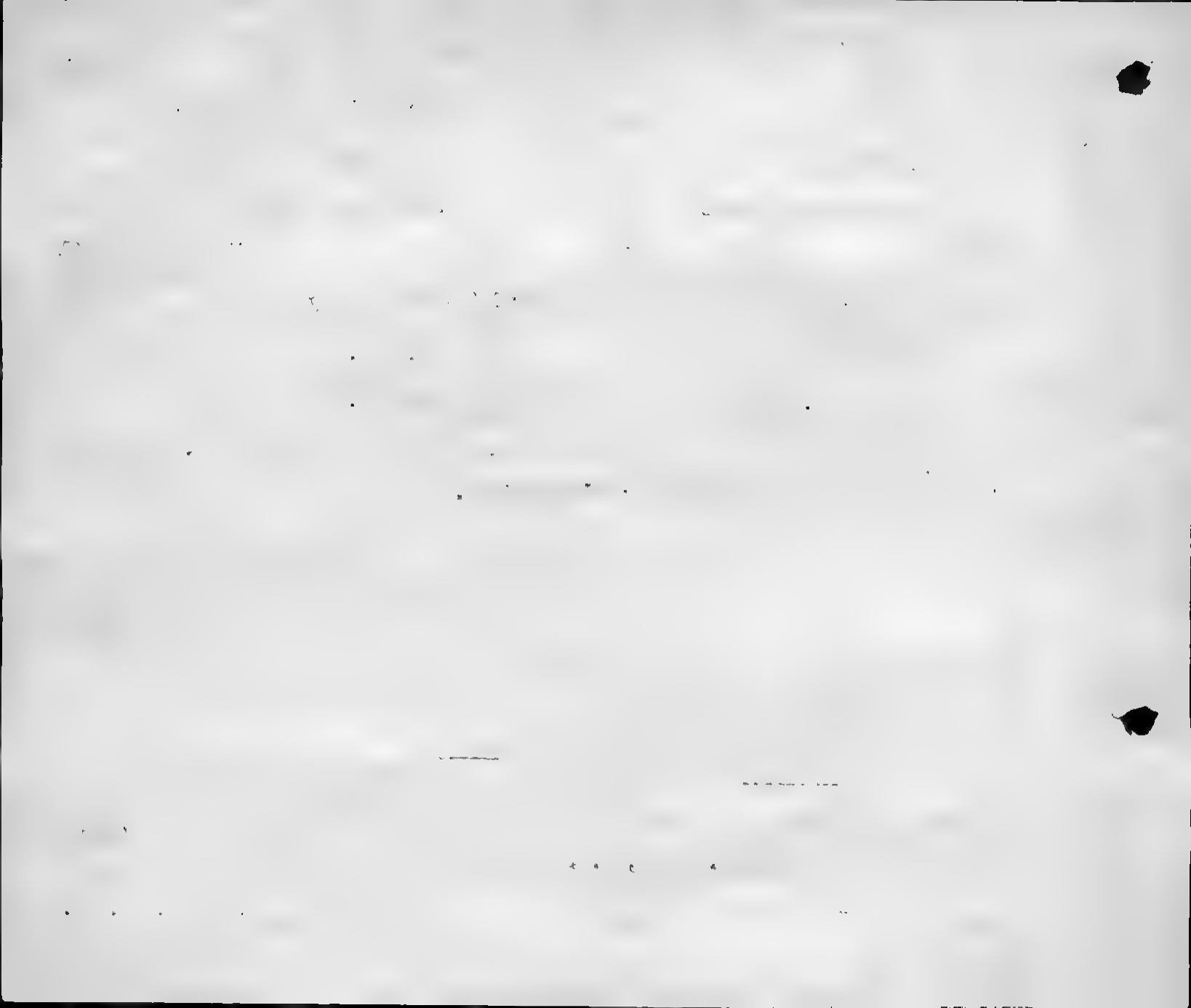
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2053

04053

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Raspeburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4913 Kenwood Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspeburg d. STREET ADDRESS 4913 Kenwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DEBORAH LEE SIPPEL		4. DATE OF DEATH Month April Day 7 Year 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1958	
9. AGE (In years last birthday) 2 yrs. 11 months 9 days		10. IF UNDER 1 YEAR 11 months 9 days	
11. IF UNDER 24 HRS. 11 hours 9 minutes		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John E. Sippel		14. MOTHER'S MAIDEN NAME Mary R. Doyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John E. Sippel		Address 4913 Kenwood Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis. DUE TO S25X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH (6)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D.	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED 4/7/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-1961	
22c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		22d. LOCATION (City, town, or country) (State) Trupp Mill Rd. Balto., Co., Md.	
23. FUNERAL DIRECTOR Charles S. Petty		ADDRESS	
24a. REC'D BY REGISTRAR APR 13 '61		24b. REGISTRAR'S SIGNATURE Charles S. Petty	



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4060

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04054

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 3 yrs 11 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BARBARA ANNE SMITH				4. DATE OF DEATH Month Day Year April 21 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1875	9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac T. Bewley				14. MOTHER'S MAIDEN NAME Margaret Kaser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Margaret Sterglemas daughter			Address 1330 N. Hollins Road Catonsville
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Assoc. w/ Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23 1957 to April 21 1961 , that (I) (we) last saw the deceased alive on April 21 1961 , and that death occurred at 11:00 PM from the causes and on the date stated above.							
22a. SIGNATURE Jose R. Arizaga M.D.				22b. DATE SIGNED 4/21/61			
22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA				22d. ADDRESS SPRING GROVE STATE HOSP.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/25/1961		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL BALTIMORE, MD.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home Catonsville				25a. REC'D BY REGISTRAR APR 25 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kiser	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04055

1
FOR STATE
DEPT.
N.Y.
X
I
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4048 Dixon Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>7048 Dixon Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. David Arthur Smith</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bendix Company</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> 11. BIRTHPLACE (State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10th</u> Year <u>1961</u> 9. AGE (in years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>			
13. FATHER'S NAME <u>John W. Smith</u> 14. MOTHER'S M.A.DEN NAME <u>Ida ?</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or date of service)</u> 16. SOCIAL SECURITY NO. <u>Mrs. Edith B. Smith</u> 17. INFORMANT <u>same</u> Address <u>same</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) } (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I/a 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a.m.</u> <u>p.m.</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>Charles F. O'Donnell</u> ASSISTANT MEDICAL EXAMINER <u>Charles F. O'Donnell</u> DEPUTY MEDICAL EXAMINER <u>Charles F. O'Donnell</u> Address (Street, city, town, or county) <u>Baltimore, Maryland</u> DATE SIGNED <u>4/11/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/13/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> 22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)				23. FUNERAL DIRECTOR <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u> 24a. REC'D BY REGISTRAR <u>APR 11 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Robert L. Ruck</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04056

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>2 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Ridgeway Nursing Home</u>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>607 DENNISON ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>GEORGE JOSEPH SMITH</u> First Middle Last 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MAY 27, 1883</u> 9. AGE (in years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUNICIPAL DIRECTOR'S ASS'T. MUNICIPAL</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE J. SMITH</u> 14. MOTHER'S MAIDEN NAME <u>SARAH JANE EASTERLEY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>216-09-1396</u> 17. INFORMANT <u>HELEN FREEMAN</u> Address <u>607 DENNISON ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (b) <u>422</u> (c), stating the underlying cause last. <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that () (this hospital) attended the deceased from <u>1940</u> to <u>4/6</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>4/5</u> , 19 <u>61</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Thos E Roach</u> 22c. PHYSICIAN'S NAME (Type) <u>Thos E Roach</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>3629 Edmondson Ave Bkto-29-M</u> 22b. DATE SIGNED <u>4/6/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-8-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Miller</u> ADDRESS <u>2101 Frederick Ave.</u>		25a. REC'D BY REGISTRAR <u>APR 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04057

6066

Item 14 Film 6203 4/20/61 JWC

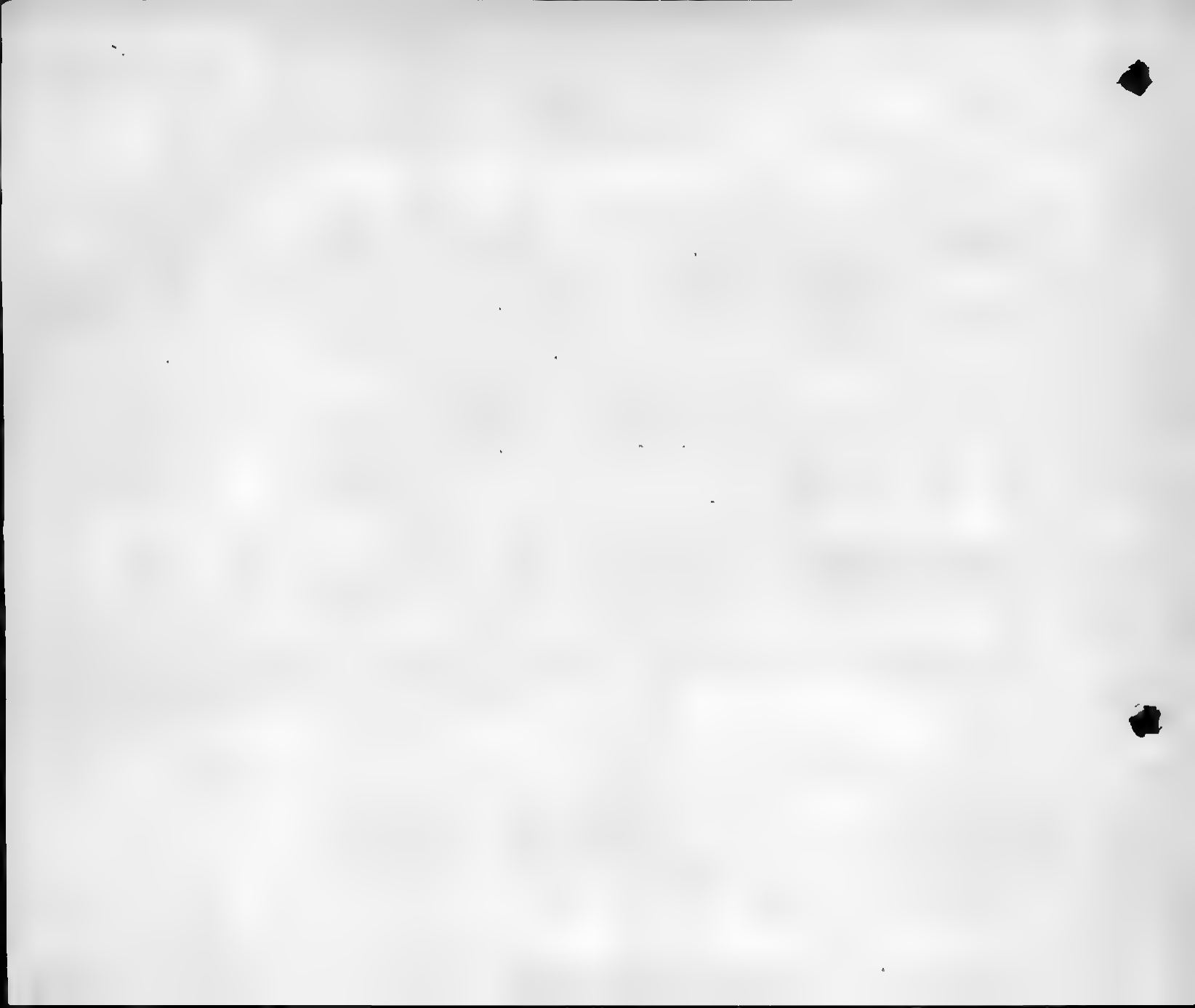
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Martin Company</u>		d. STREET ADDRESS <u>5 Lightwood Road</u>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>R.</u> Middle <u>Smith</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>12th</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20, 1911</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>The Martin Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Bertha unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>213-01-6179</u>	
17. INFORMANT <u>Mrs. Lida C. Smith</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>APR 14 61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Frank</u>	

MEDICAL CERTIFICATION

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04058

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) OVERLEA				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4811 KENWOOD AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 4811 KENWOOD AVE							
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET SMITH				4. DATE OF DEATH Month Day Year APRIL 26 1961			
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 6, 1902		9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY				10b. KIND OF BUSINESS OR INDUSTRY WOOLWORTHS		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES ROSE				14. MOTHER'S MAIDEN NAME HAUNAN NIEMEYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 218-28-0358		17. INFORMANT HERMAN P SMITH Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion							years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Artero-sclerotic cardio-vascular disease DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Rheumatoid arthritis, severe							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/24 19 61 , to 4/26 19 61 , that (I) (we) last saw the deceased alive on 4/24 19 61 , and that death occurred at A M, from the causes and on the date stated above							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED 4/28/61			
22c. PHYSICIAN'S NAME (Type) J. J. Samuels, M.D.				22d. ADDRESS Franklin Square Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 29, 1961		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION (City, town, or county) (State) PARKVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Josephine Funeral Home 7401 Belair Rd #6				25a. REC'D BY REGISTRAR MAY 1 '61		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital, attending physician, or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



4065

CERTIFICATE OF DEATH

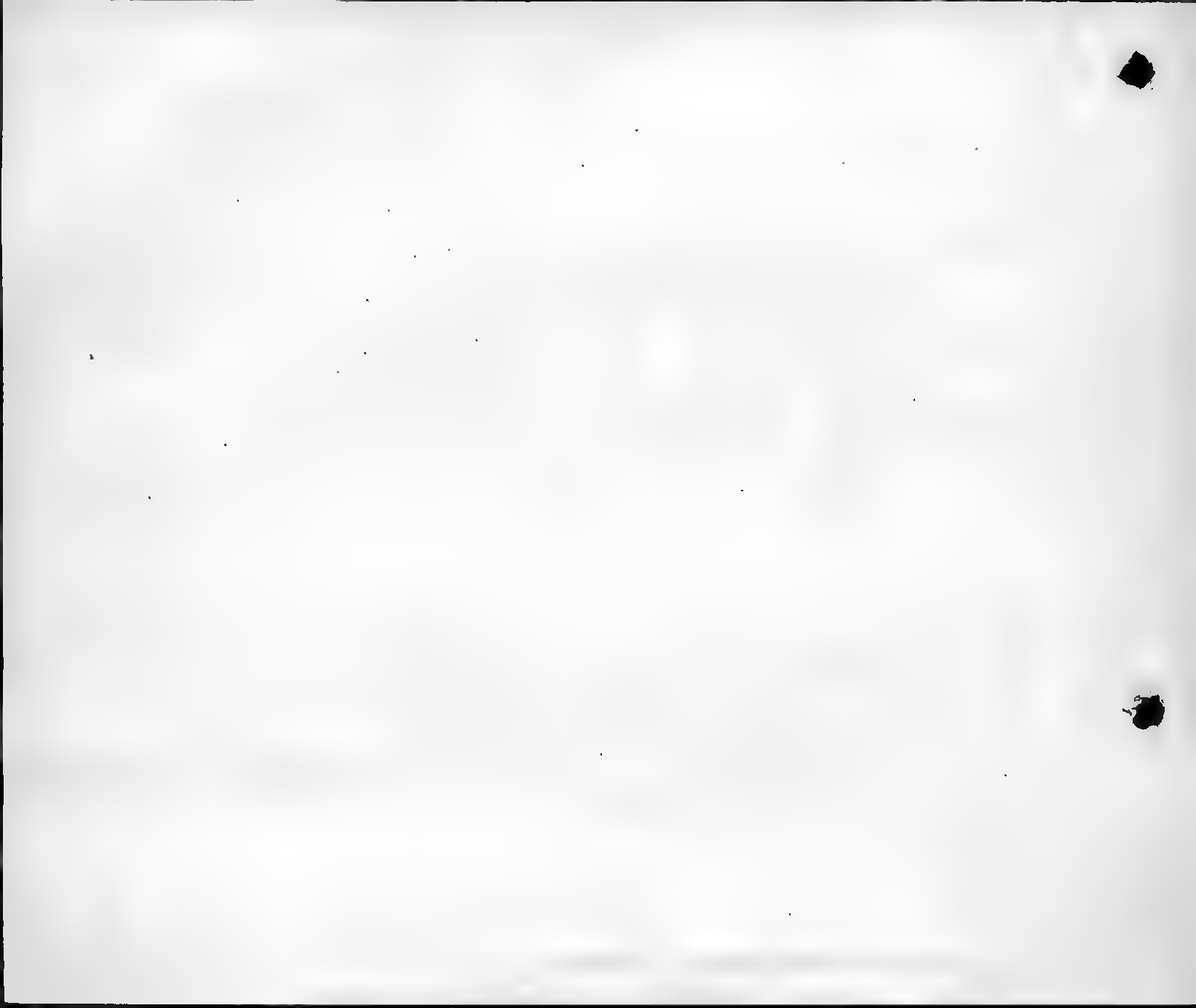
Reg. Dist. No. 04059

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209 COLGATE AVE</u>		d. STREET ADDRESS <u>209 COLGATE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD</u> First Middle Last <u>SPALDING</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>AUTO MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AMOS SPALDING</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN CONRAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>099-05-4057A</u>	
17. INFORMANT <u>MRS. JESSIE KURTZ</u>		Address <u>209 COLGATE AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA of Left Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to Brain</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>17 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> 19 <u>59</u> to <u>April</u> 19 <u>61</u> , that I last saw the deceased alive on <u>March 31</u> , 19 <u>61</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. J. W. M.S.</u>		ADDRESS (Street, city or town, state) <u>M.D. 6800 Mornington - 4/3/61</u>	
PHYSICIAN'S NAME (Type) <u>Dundalk - Dr. M. J. W.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>APR. 4, 1961</u>	<u>PARKWOOD CEMETERY</u>	<u>PARKVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME, DUNDALK, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carroll L. Hearn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

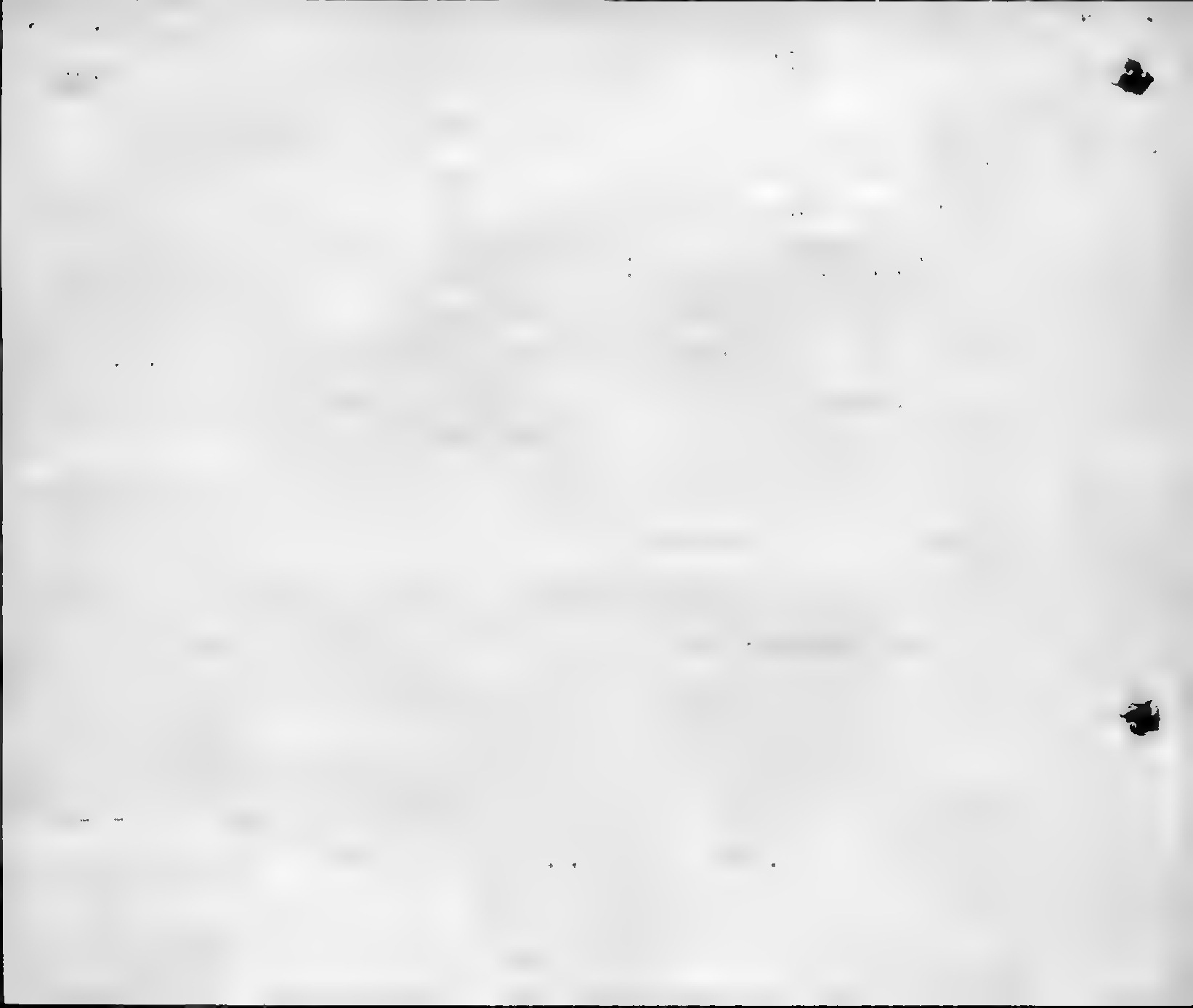
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04060

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b <u>7 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. den't before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12</u> d. STREET ADDRESS <u>325 Winston Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>S.A. JOHN ARTHUR A. SPEAR SPEAR</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 2, 1893</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John R. Spear</u> 14. MOTHER'S MAIDEN NAME <u>Lillian E. Unduch</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u> 16. SOCIAL SECURITY NO. <u>216 05-1203</u> 17. INFORMANT <u>VAH, BALTIMORE 18, MARYLAND, Ft. Howard Division</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO (b) <u>DELERIUM TREMENS</u> DUE TO (c) <u>CHRONIC ALCOHOLISM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>7 DAYS</u> <u>MANY YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Corneal Ulceration, Right Eye</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that (a) (this hospital) attended the deceased from <u>April 18, 1961</u> to <u>April 25, 1961</u> , that (b) (we) last saw the deceased alive on <u>April 25, 1961</u> , and that death occurred at <u>12:10</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Daniel R. Zoll</u> 22c. PHYSICIAN'S NAME (Type) <u>DANIEL R. ZOLL</u> 22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>		22b. DATE SIGNED <u>4-25-61</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-28-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Seitz Funeral Home</u> 25a. REC'D BY REGISTRAR <u>MAY 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04061

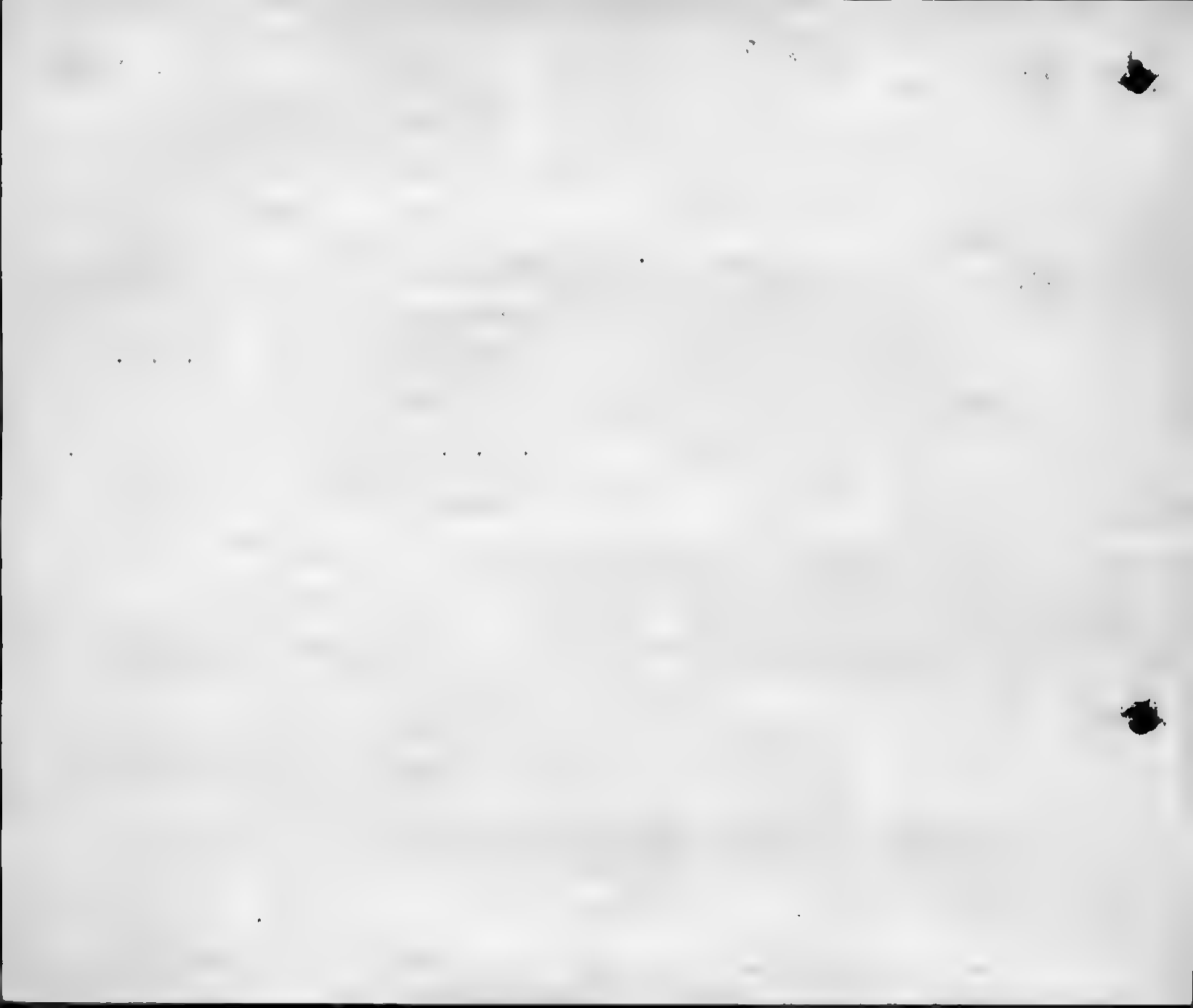
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(M)

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in the Pines Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>1817 Fairview Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Anna R. Spitzer</u>		4. DATE OF DEATH <u>April 27, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4, 1874</u>
9. AGE (In years, last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>	
11. IF UNDER 24 HRS. Hours <u>15</u> Min. <u>30</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Wm. B. McCloskey-6306 Mossway Balto. 12</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>1530</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> M. <u>PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-30-1948</u> to <u>4-27-1961</u> , that (I) (we) last saw the deceased alive on <u>4-25-1961</u> , and that death occurred at <u>2450</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u>4-28-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher M.D.</u>		22d. ADDRESS <u>6207 Frederick Rd., Baltimore 28, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>4-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 1 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

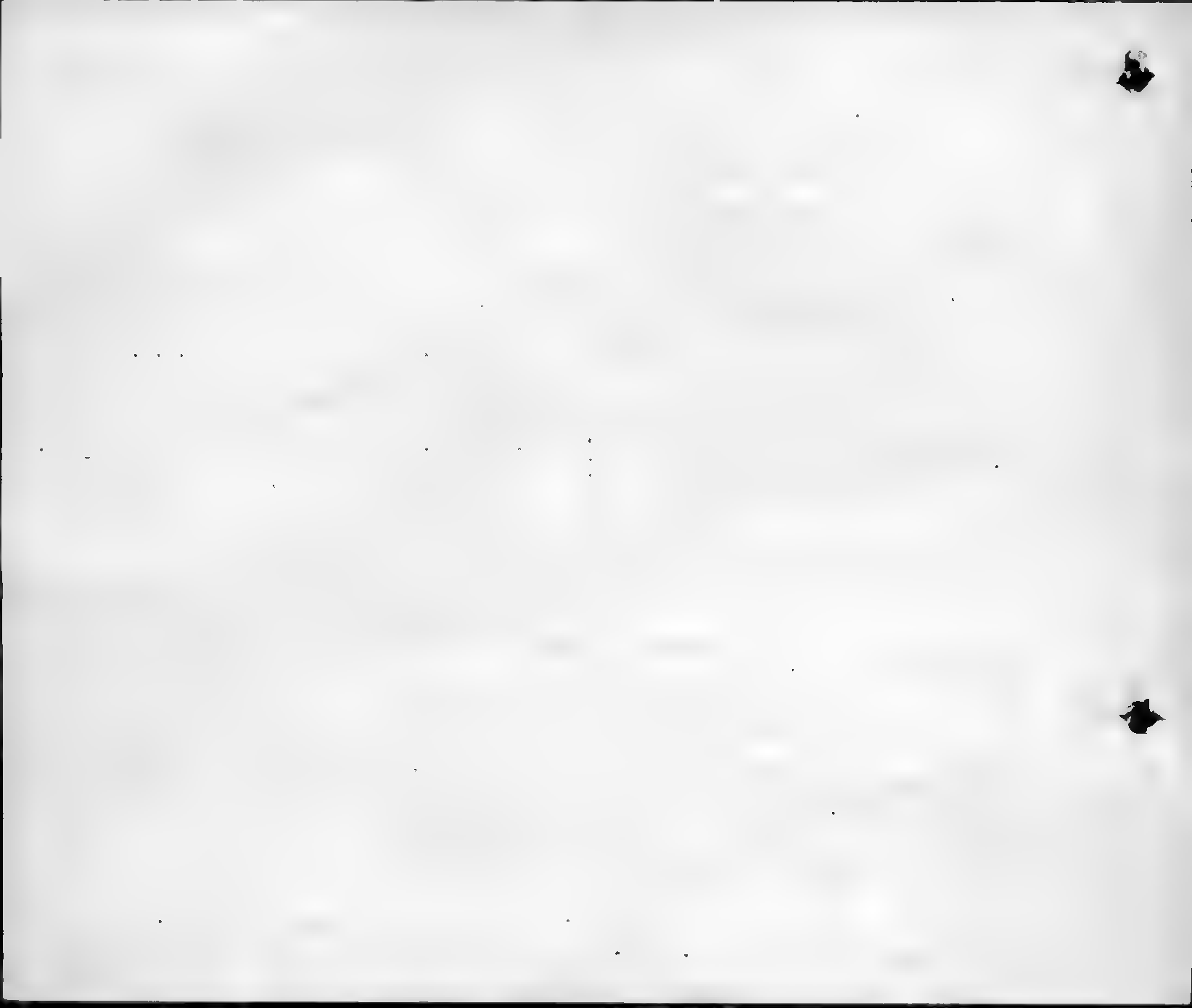


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO., MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEAMERS RUN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEAMERS RUN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 542 STEAMERS RUN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last SPONHEIMER		4. DATE OF DEATH Month APRIL Day 9 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-1905
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 5 Days 11 Hours 15 Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE LIEUT.		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST SPONHEIMER		14. MOTHER'S MAIDEN NAME KATHERINE WIEGAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. ANNA E. SPONHEIMER		Address 542 STEAMERS RUN RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Carcinoma of Larynx Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Carcinoma of Larynx (c) Carcinoma of Larynx		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to April 9, 1961 , that (I) (we) last saw the deceased alive on April 9, 1961 , and that death occurred at 4 P. M. from the causes and on the date stated above			
22a. SIGNATURE Wm. Gardner		22b. DATE SIGNED 4/11/61	
22c. PHYSICIAN'S NAME (Type) Wm. Gardner		22d. ADDRESS Balto 6 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-13-61	
23c. NAME OF CEMETERY OR CREMATORY ZION LUTH. CEM		23d. LOCATION (City, town, or county) (State) STEAMERS RUN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Samuel Fun'l Home 741 Belair Rd.		25a. REC'D BY REGISTRAR DATE APR 13 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Evans			



VS. AISME
SM 9/60

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

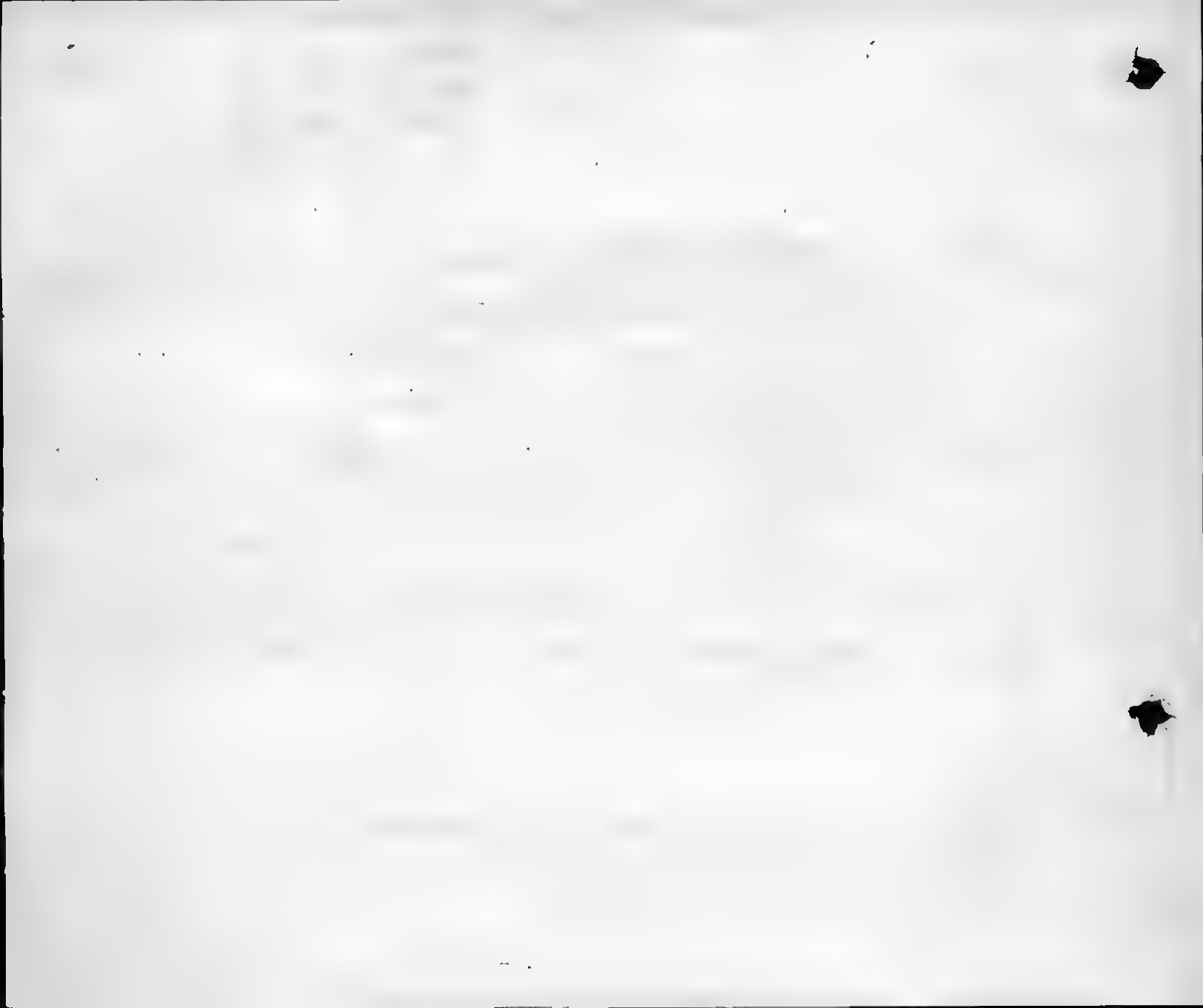
CERTIFICATE OF DEATH

Reg. Dist. No. **04064**

2070

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admittance) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
c. LENGTH OF STAY IN 1b 2 years.		d. STREET ADDRESS 305 Eastern Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at her home.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSELIA Middle VICTORIA Last STABLER		4. DATE OF DEATH Month April Day 15 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March-20-1911
9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min 50	IF UNDER 24 HRS Months 50 Days 50 Hours 50 Min 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Michael Takacs	
14. MOTHER'S MAIDEN NAME Ida Phillips		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 261-60-1530		17. INFORMANT Mr. A. Earl Stabler (husband) Address 305 Eastern Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchial Pneumonia DUE TO Operations Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Intestinal Obstruction DUE TO Peritonitis Ruptured Stomach Ulcer		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14, 1961 to April 15, 1961 , that I last saw the deceased alive on April 15, 1961 , and that death occurred at 10 P. M. from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) Baltimore Md	
ACTUAL SIGNATURE L. M. Baumgardner M.D.		DATE SIGNED 4/16/61	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF April-18-1961	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore 29, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Stewart & Mowen Co., 108-W-North-Av. Balto. 1-Md		24. REC'D BY REGISTRAR DATE APR 17 '61	
24b. REGISTRAR'S SIGNATURE Carlton S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



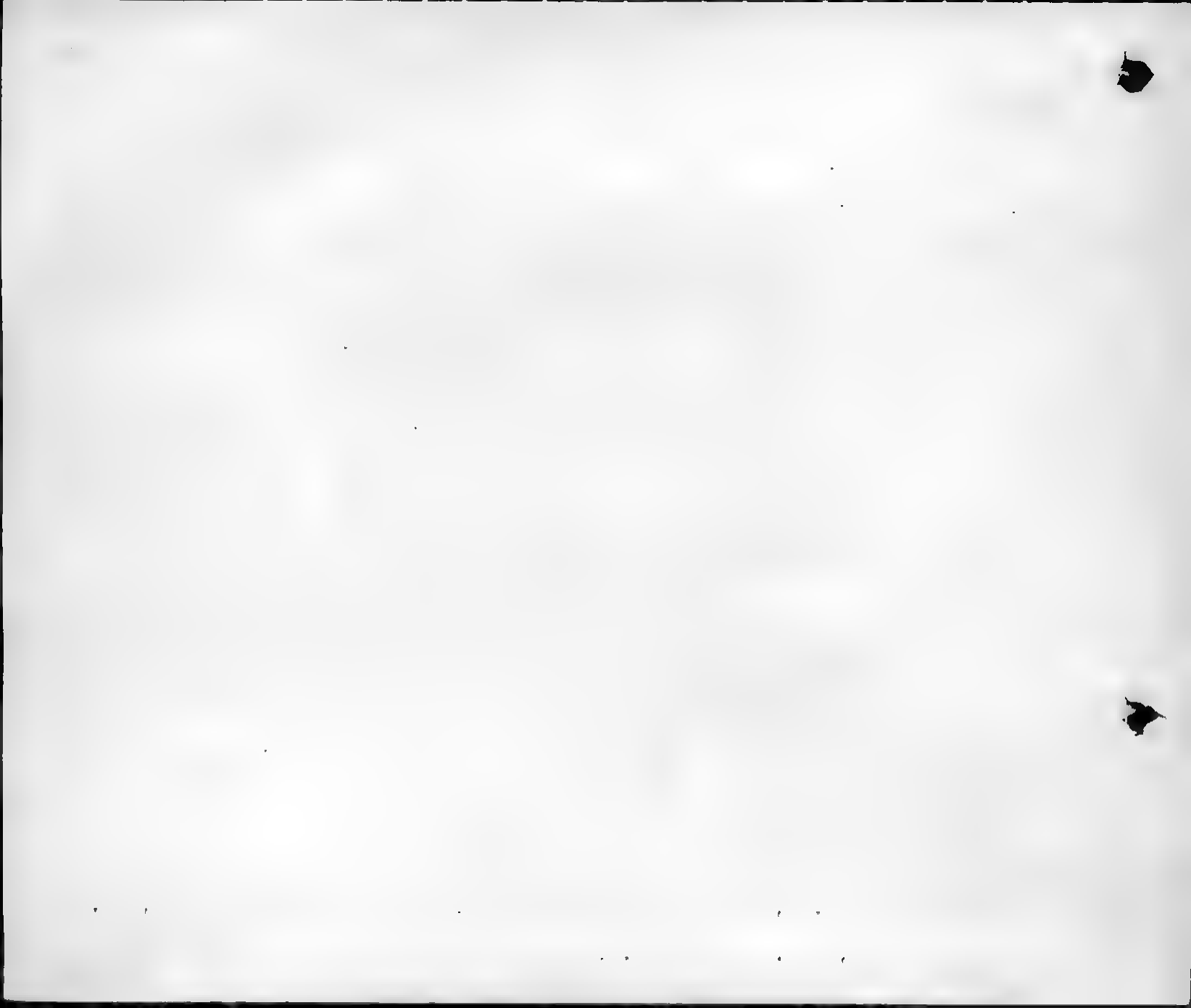
Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4071

04065

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MADONIC HOME</u>		d. STREET ADDRESS <u>5917 BRUCESS AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>STANLEY</u> Last <u>—</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1961</u>	
5 SEX <u>FE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MARTIN KRAFT</u>		14. MOTHER'S MAIDEN NAME <u>PALLINE STENGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hank L. Smith Jr. Cockeysville, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Vascular Accident</u> 11431 DUE TO <u>Hypertensive Arteriosclerotic Cordis</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>6-10</u> 19 <u>61</u> to <u>4-21</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>4-21</u> 19 <u>61</u> , and that death occurred at <u>6 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter T. Kees</u>		22b. DATE SIGNED <u>4/22/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>		22d. ADDRESS <u>COCKEYSVILLE MD</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 26, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>	
ADDRESS <u>1217 St. Paul Street</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Friend</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5 Form 6-60

04066

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (if outside corporate limits, give RURAL and give nearest town)

c. LENGTH OF STAY IN b.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF DECEASED
(Type or print)

5. SEX

6. COLOR OF FACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (in years last birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUPLICATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUPLICATE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

22a. BURIAL, CREMATION

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

APR 10 '61

Funeral Director: P. Deemann 6067 Harbor Rd

DATE

APR 10 '61

EXAMINER'S NAME (Type): C.E.O. S. M. KIEFFER

22a. BURIAL, CREMATION: Burial

22b. DATE THEREOF: Apr. 7, 61

22c. NAME OF CEMETERY OR CREMATORY: Romanee Cem

22d. LOCATION (City, town, or county): Balto Md

23. FUNERAL DIRECTOR: P. Deemann 6067 Harbor Rd

24a. REC'D BY REGISTRAR: DATE

24b. REGISTRAR'S SIGNATURE: Arthur L. Krasner

MEDICAL CERTIFICATION

I

M

2072

4/10/61 JWH

a. STATE: Md

b. COUNTY: Balto City

c. CITY OR TOWN (If outside corporate limits, with RURAL and give nearest town): Villa Nova Balto Md

d. STREET ADDRESS: 308 Northern Pkwy

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

f. Steigelmater

Month

Day

Year

8. DATE OF BIRTH: July 14, 1876

9. AGE (in years last birthday): 84

10. USUAL OCCUPATION: Nurse

11. BIRTHPLACE: Ireland

12. CITIZEN OF WHAT COUNTRY? Irish

13. FATHER'S NAME: Henry A. Grode

14. MOTHER'S MAIDEN NAME: Mary R. Beasley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT: W. L. Linsbary

Address: Sup't of Home

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUPLICATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUPLICATE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

22a. BURIAL, CREMATION

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

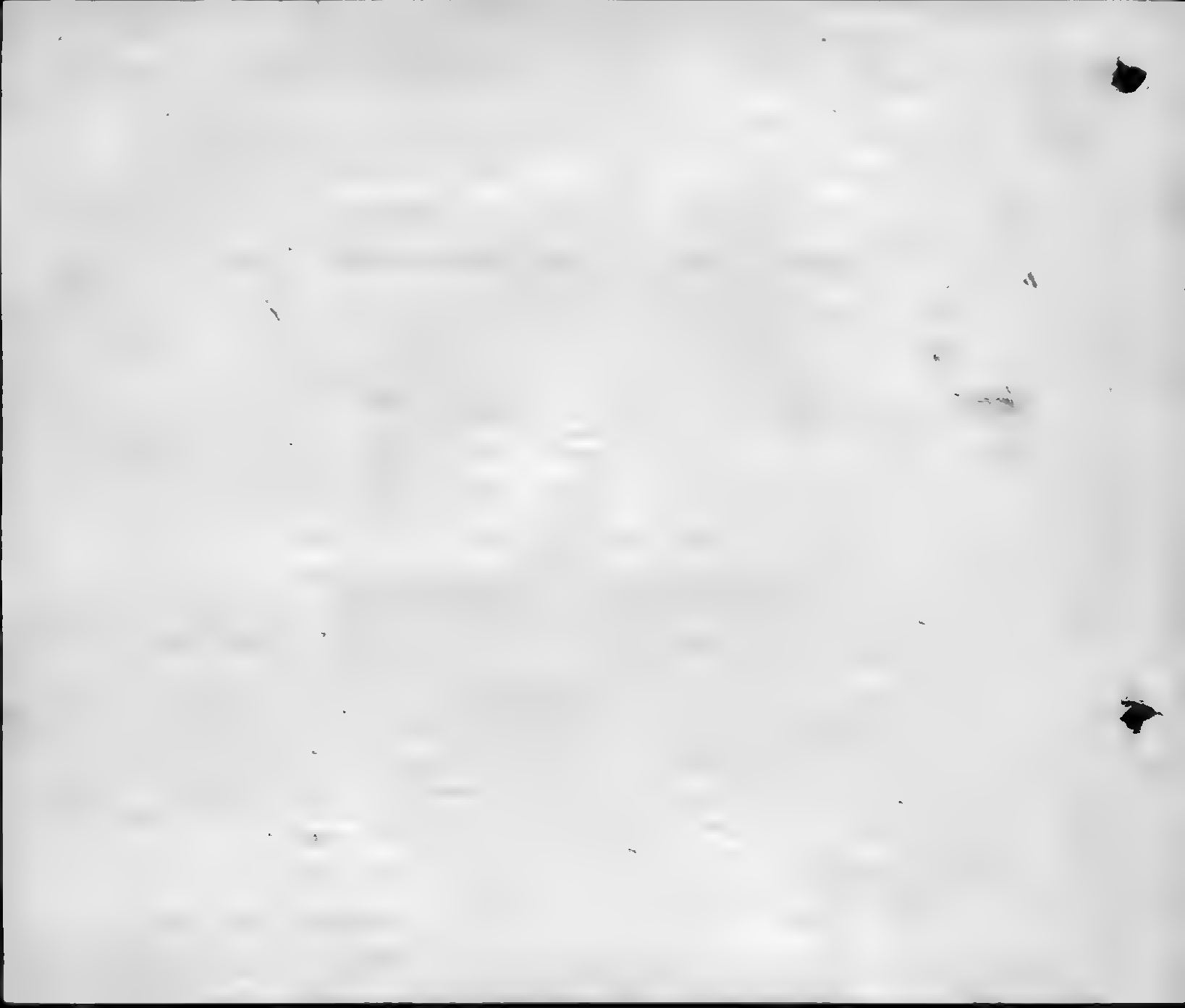
DATE

APR 10 '61

Funeral Director: P. Deemann 6067 Harbor Rd

24a. REC'D BY REGISTRAR: DATE

24b. REGISTRAR'S SIGNATURE: Arthur L. Krasner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, attending physician, or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1d. Film 3284 4/7/61 iwk

4073

CERTIFICATE OF DEATH

Reg. Dist. No. 04067

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>21 MO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Women & Aged Men's Home</u> <u>615 Chestnut Ave. Towson 4, Md.</u>				d. STREET ADDRESS <u>7 S. PAYSON ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>E.</u> Last <u>STOLZENBACH</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1867</u> 93 yrs.	
9. AGE (In years last birthday) <u>93</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>ECKHART STOLZENBACH</u>			
14. MOTHER'S MAIDEN NAME <u>ANNA WIEGAND</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>215 22 6012</u>				17. INFORMANT <u>DAISY E. HAMILTON, R.N. 615 Chestnut Ave. Towson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio-renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholelithiasis and Cholelithiasis?</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>April 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>61</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald Edward Day</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E-332 St Balto 18 April, 1961</u>			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred. A. Cole 1913 W. Balto. St.</u>				24a. REC'D BY REGISTRAR <u>APR 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kane</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04068**

4074

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONG GREEN		c. LENGTH OF STAY IN lb 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) LONG GREEN	
		f. STREET ADDRESS 1 HANE ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last EMMA ADELIA STREETT		4. DATE OF DEATH Month Day Year APRIL 16 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) WHITE FORD MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HUGH C. WHITE FORD		14. MOTHER'S MAIDEN NAME PHOEBE FLA HARTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO —	
17. INFORMANT CHARLES H. STREETT		Address GLEN ARM MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency DUE TO (c) Arteriosclerotic CVD		INTERVAL BETWEEN ONSET AND DEATH Immediate 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1957 , to April 1961 , that I last saw the deceased alive on 4-14-61 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 4-17-61			
ACTUAL SIGNATURE William A. Tyson M.D.		PHYSICIAN'S NAME (Type) William A. Tyson	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/19/1961	
22c. NAME OF CEMETERY OR CREMATORY WILLIAM WATERS		22d. LOCATION (City, town, or county) (State) COOPTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Gutz ADDRESS Jarrettsville, Md.		24a. REC'D BY REGISTRAR DATE APR 19 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Finner	

Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4075

04069

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY A.A.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN TB 1 1/2 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ferndale	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS 305 Oakley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Donald Sullivan		4. DATE OF DEATH Month 4 Day 5 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/29/16		9. AGE (in years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 4 Days 5 IF UNDER 24 HRS Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Clarence Paola Sullivan (deceased)		14. MOTHER'S MAIDEN NAME Bertie Estelle McCullough (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Rosewood Records, Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute meningitis DUE TO (b) Acute bronchopneumonia with abscesses DUE TO (c) abscesses		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ---		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ---			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---		20g. (County) ---		20h. (State) ---	
21. I certify that (I) (this hospital) attended the deceased from 9:50 A.M. to 10:00 A.M. , 19 61 , that (I) (we) last saw the deceased alive on 4-5-61 , and that death occurred at 9:50 A.M. from the causes and on the date stated above.					
22a. SIGNATURE W. Rieckert		22b. DATE 4-5-61		22c. PHYSICIAN'S NAME (Type) W. Rieckert	
22d. ADDRESS 4307 Monfield Ave, Balt 14		22e. M.D. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/>	
22g. STAFF PHYS. <input type="checkbox"/>		22h. PHYSICIAN'S NAME (Type) ---		22i. ADDRESS ---	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/8/61		23c. NAME OF CEMETERY OR CREMATORY ---	
23d. LOCATION (City, town or county) ---		23e. (State) ---		23f. (Country) ---	
24. FUNERAL DIRECTOR'S SIGNATURE Paul E. Charonoff		24a. ADDRESS 3617 Chestnut Ave		25a. REC'D BY REGISTRAR APR 7 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE APR 7 '61		25d. (State) ---	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used.

IG PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4076

04070

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN 1b

62 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF DECEASED
(Type or print)

ESTEBAN

First Middle

S.

TAGUIBOLOS

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11/22/96

4. DATE OF DEATH

APRIL

Month

17

Day

19 61

Year

9. AGE (In years last birthday)

64

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fireman & Water Tender

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (County & State, or foreign country)

Phillipine Islands...

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Antonio Taguibolos

14. MOTHER'S MAIDEN NAME

Simplicio Bagcion

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO

217-14-2731

17. INFORMANT

Address

Clin. Rec. VAH, Balto. Md. Ft. Howard Division

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

BRONCHO PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) (c)

CONGESTIVE HEART FAILURE

ARTERIOSCLEROTIC HEART DISEASE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

MYOCARDIAL SCARRING, NEPHROSCLEROSIS, ARTERIO-SCLEROTIC

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from **2/14/1961** to **4/17/1961** that (we) last saw the deceased alive on **April 17, 1961**, and that death occurred at **4:40 AM**, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Thomas F. Crahan, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

☒

22b. DATE SIGNED

4/17/61

22d. ADDRESS

VAH, Balto. Md. Fort Howard Division

23b. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23c. DATE THEREOF

4-20-61

23c. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

23d. LOCATION (City, town or county)

Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Elroy Wilson Funeral Home, Baltimore, Maryland

25a. REC'D BY REGISTRAR

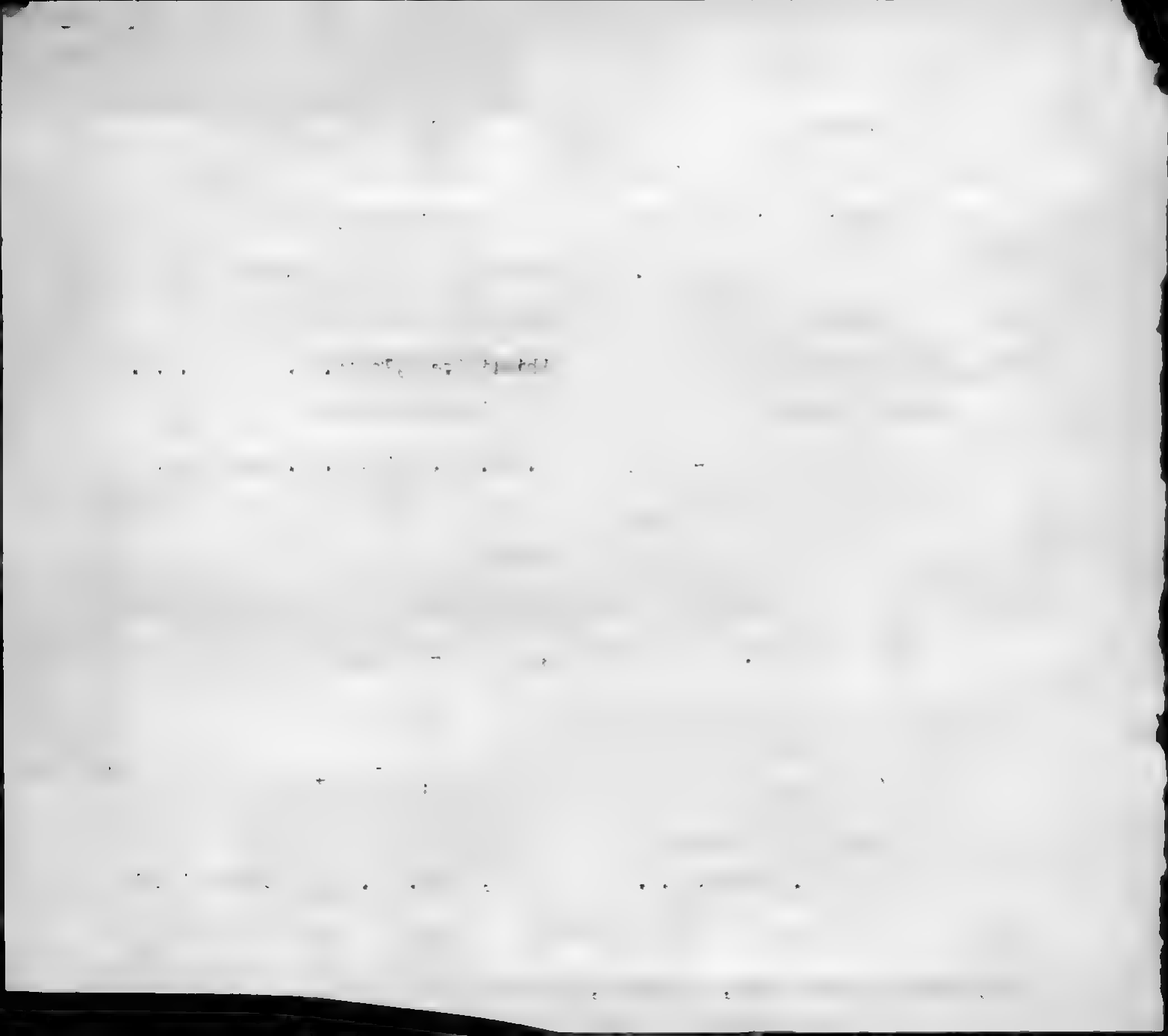
MAY 1 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. ...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A15 (4)
A 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

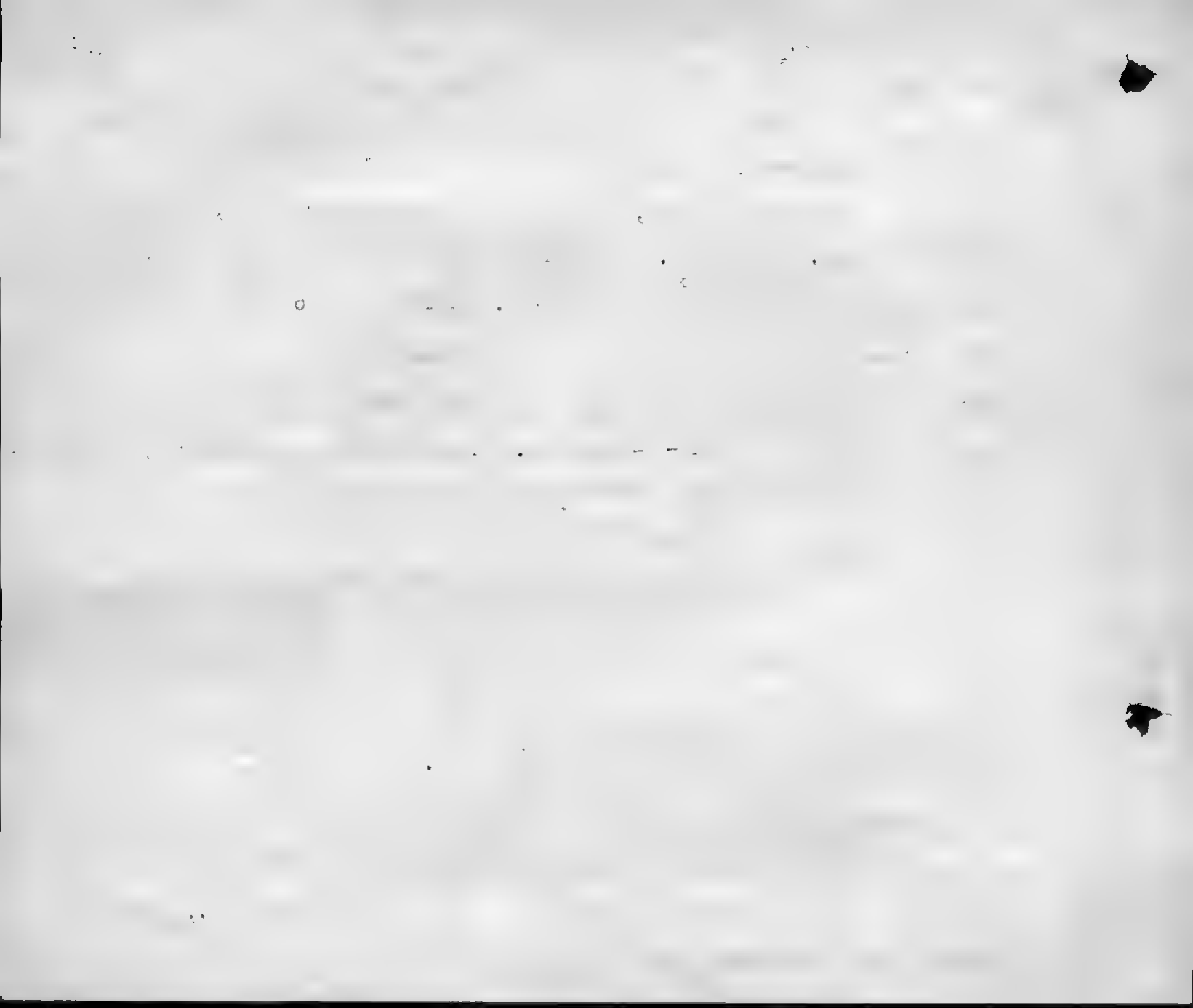
CERTIFICATE OF DEATH

04071

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greenspring Avenue, RFD #1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>Greenspring Avenue, RFD #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Naomi A. Tanner</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1898</u> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Simeon Van Trump</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Trout</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-22-8725</u>	
17. INFORMANT <u>C. Ellsworth Tanner</u>		Address <u>Greenspring, Lutherville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) <u>Hypertensive C.V. Disease</u> (c) <u>Diabetes Mellitus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12-30 1958</u> to <u>April 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr 3, 1961</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M Paul Byerly</u> 22c. PHYSICIAN'S NAME (Type) <u>M Paul Byerly</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>3033 W. 14th St. A</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 6, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> <u>Horace F. Burgee</u>		25a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>	
ADDRESS <u>3631 Falls Road</u> <u>Baltimore</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital, attending physician, or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

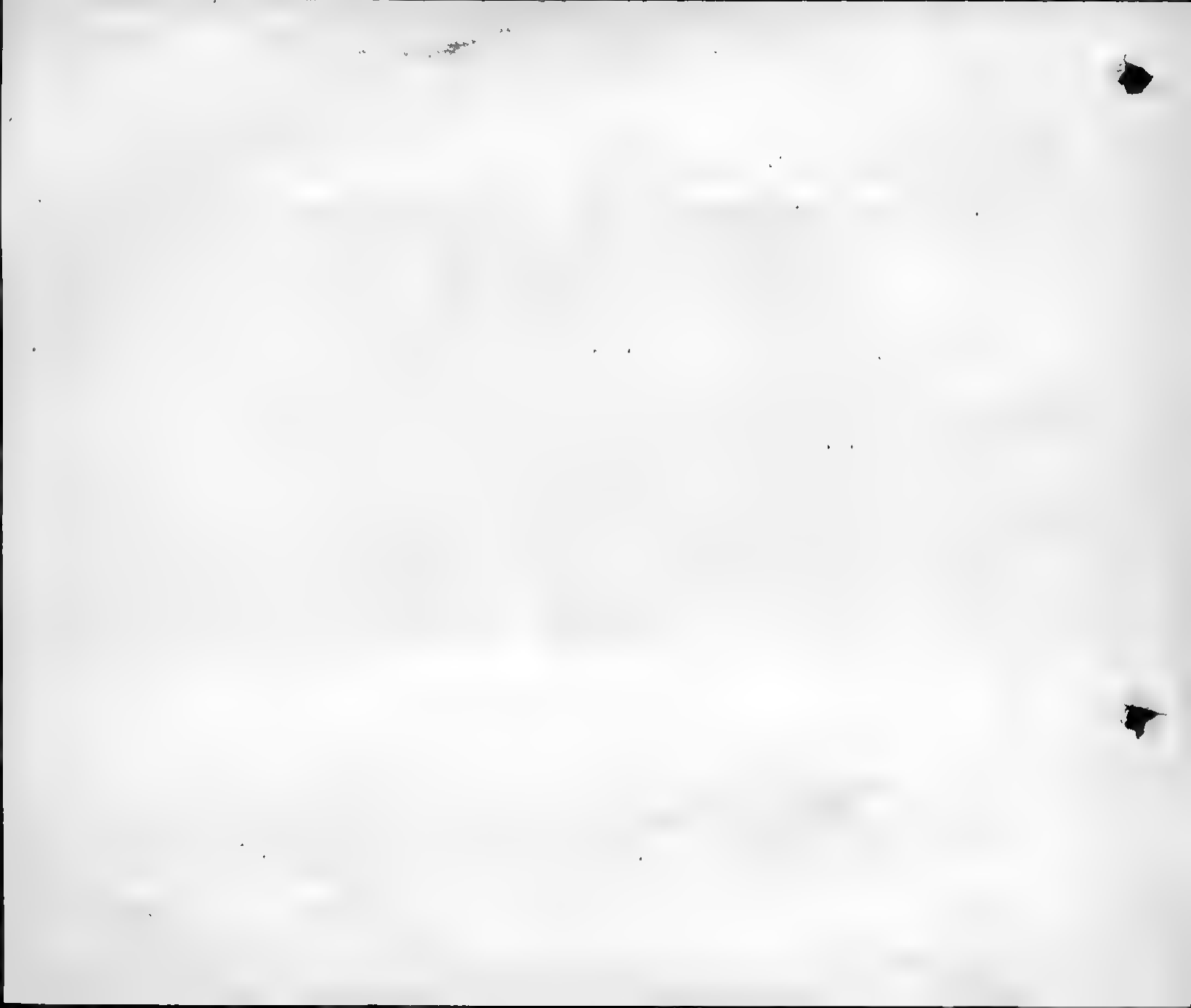
04072

4073

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28, Md.</u>				c. LENGTH OF STAY IN 1b <u>2 yrs 4 mos +</u>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27, Maryland</u>				d. STREET ADDRESS <u>5510 Carville Avenue</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>George</u> Last <u>Tello</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/5/96</u>			
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna R. R.</u>		11 BIRTHPLACE (State or foreign country) <u>Portugal</u>			
12 CITIZEN OF WHAT COUNTRY? <u>Naturalized U.S.</u>									
13. FATHER'S NAME <u>George Tello</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO <u>717-07-6981</u>					
17. INFORMANT <u>RECORDS: SPRING GROVE STATE HOSPITAL</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure due to arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>March 27, 19 60</u> to <u>April 20, 19 61</u> that (I) (we) last saw the deceased alive on <u>April 20, 19 61</u> and that death occurred at <u>9p.</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Stella Wachler</u>				22b. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville 28, Maryland</u>					
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachler M.D.</u>				22d. DATE <u>April 21, 1961</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>4/24/61</u>		<u>Meadowridge Cemetery</u>		<u>Borsey Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amber Inc. 1328 Sulphur Spring Rd.</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			
DATE <u>APR 24 '61</u>									

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

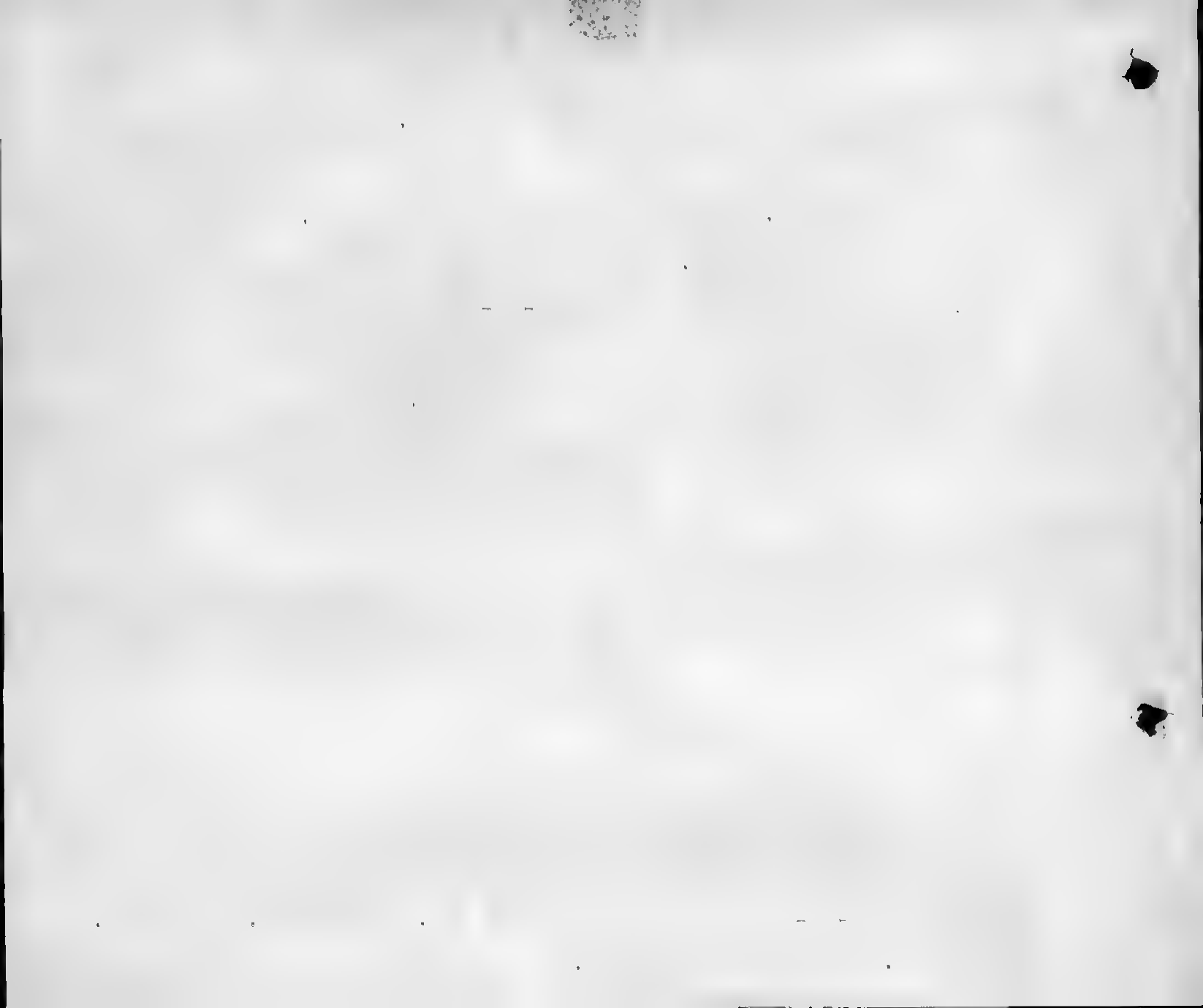
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4073

04073

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3020 East Ave.</u>		d. STREET ADDRESS <u>3020 East Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth M. Tewey</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-26-1868</u>	9. AGE (In years last birthday) <u>93</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Gerhardt Leubehusen</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Prenger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1960</u> to <u>Apr. 8, 1961</u>, that (I) (we) last saw the deceased alive on <u>4/10</u> 19<u>61</u>, and that death occurred at <u>10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Noten Janney</u>		22b. ADDRESS <u>7101 Harford Rd.</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>APR 11 61</u>	
25b. REGISTRAR'S SIGNATURE <u>W. H. S. Flannery</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

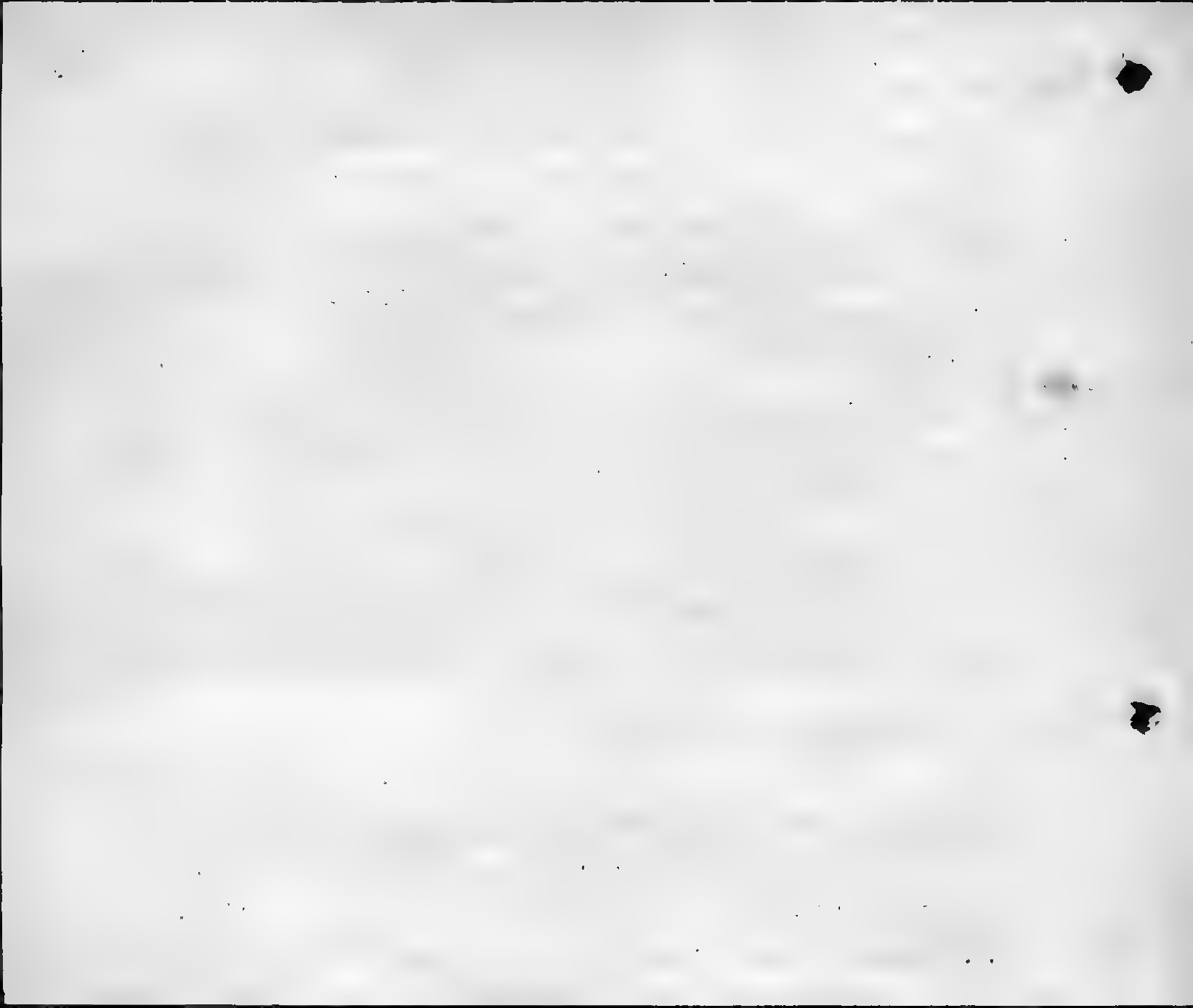
VR A15 (4)
15M 9/60

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
4090														
04074														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>16yr11mth11dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaitersburg, Maryland</u> d. STREET ADDRESS <u>Route #2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Thompson</u>					4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 61</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1887</u>		9. AGE (In years last birthday) <u>73</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <u>Andrew King</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Thompson</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 42221 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1961</u> to <u>April 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 7, 1961</u> , and that death occurred at <u>3:10 p.m.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Stella Wachsler</u> M.D.					22b. DATE SIGNED <u>4-7-61</u>									
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Linthicum Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Clarksville, Md</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>F.C.Higinbotham, Ellicott City, Md</u>					25a. REC'D BY REGISTRAR <u>APR 10 '61</u>					25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4081

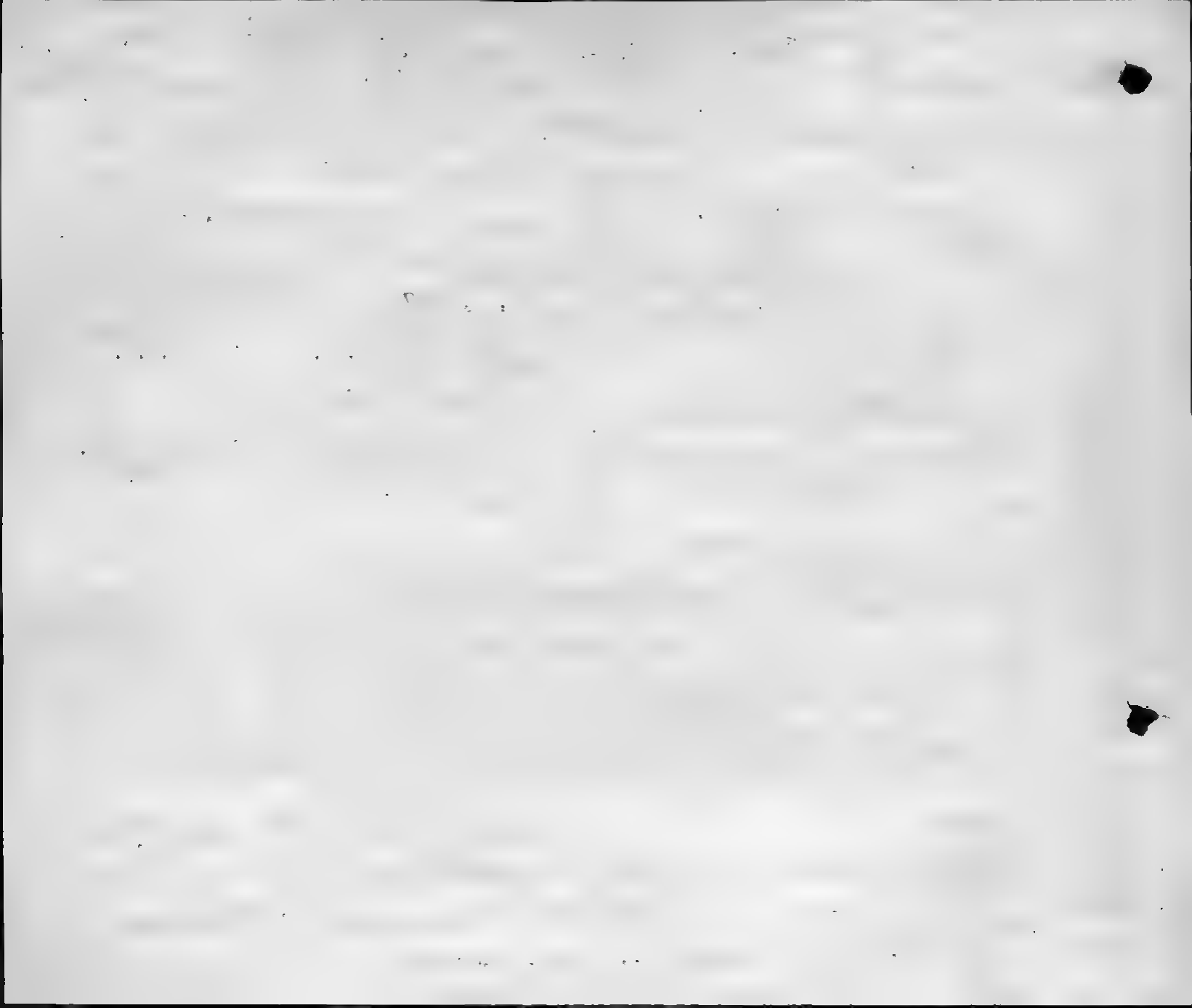
04075

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 621 New Pittsburgh Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 621 Pittsburgh Ave. -22 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HELEN Middle MELTON Last THORNTON		4. DATE OF DEATH Month April Day 27 Year 1961							
5. SEX Female		6. COLOR OR RACE Colored							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1917							
9. AGE (In years last birthday) 43 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville, N. C.							
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Earl Meadows							
14. MOTHER'S MAIDEN NAME Loraine Forbes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)							
16. SOCIAL SECURITY NO. 218-14-7445		17. INFORMANT DeRoy Thornton - 621 New Pittsburgh Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Hydrothorax + Ascaris DUE TO (b) Aortic Stenosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) _____									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) (County) (State) _____							
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>[Signature]</i> EXAMINER'S NAME (Type) _____		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-61							
22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave., Balto., Md.		24a. REC'D BY REGISTRAR May 1 '61							
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		DATE SIGNED April 27, 1961							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

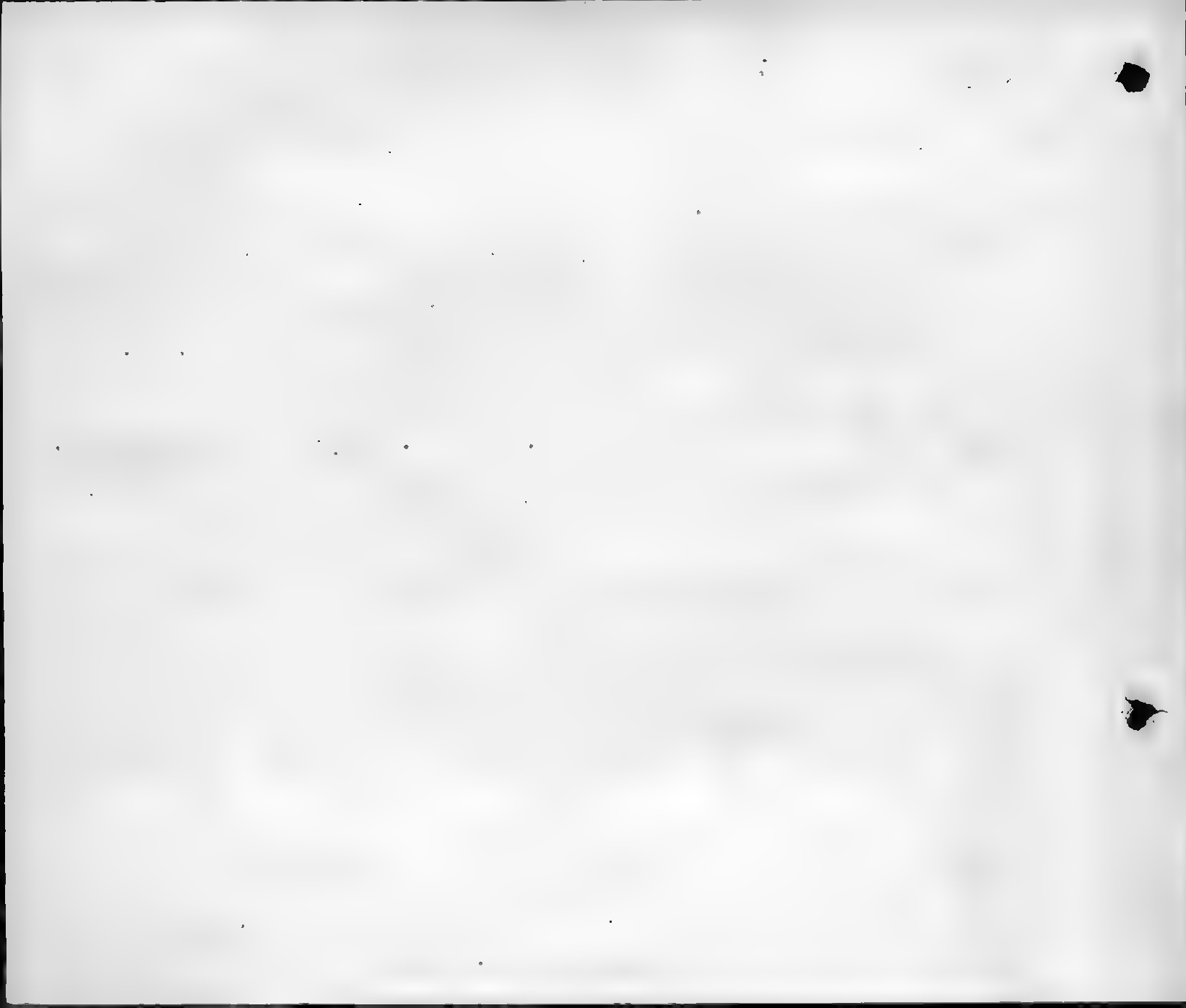
4083

CERTIFICATE OF DEATH

Reg. Dist. No.

04076

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b 60 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6700 Brighton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DR. HARRY ALVIN UHLER		4. DATE OF DEATH April 27, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1874	
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor		10b. KIND OF BUSINESS OR INDUSTRY Professional	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Uhler		14. MOTHER'S MAIDEN NAME Annie Spurrier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Ellen C. Uhler		Address 6700 Brighton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO-VASCULAR DIS. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FALL, 1952 , to APRIL 27, 1961 , that I last saw the deceased alive on APRIL 27, 1961 , and that death occurred at 7:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE MARVIN GOLDSTEIN		ADDRESS (Street, city or town, state) 5314 LIBERTY HEIGHTS AVE. BALTIMORE 7, MD	
DATE SIGNED 4/27/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1961	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William E. Johnson		ADDRESS 1557 Northren Pkwy. Baltimore 12, Md.	
24a. REC'D BY REGISTRAR MAY 1 '61		24b. REGISTRAR'S SIGNATURE William E. Johnson	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

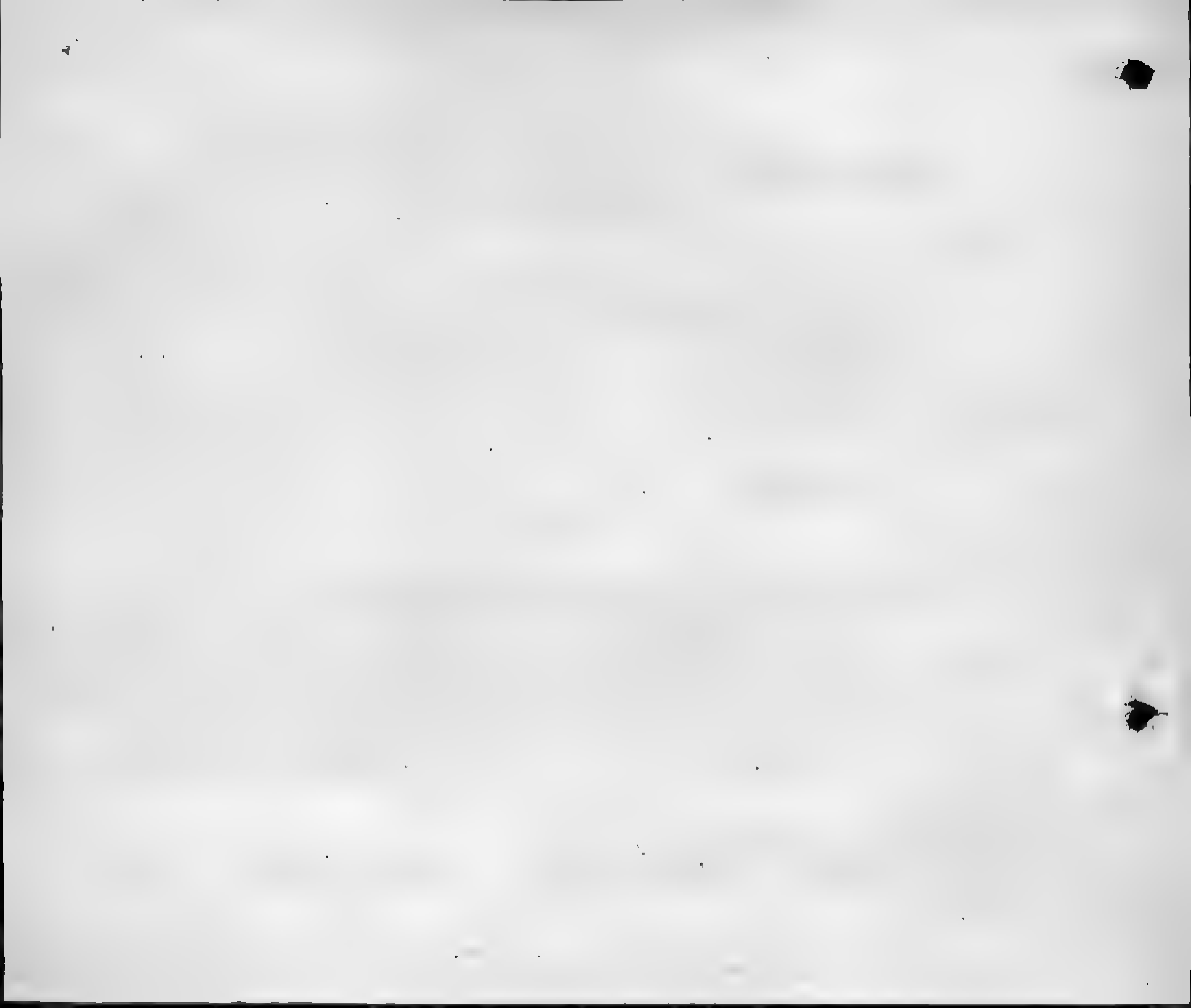
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4083

04077

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville (28)</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Caton Ridge Nursing Home, 329 Harlem La.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>265 W. Madison St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nellie Wagner</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/31/1886</u>		9. AGE (in years last birthday) <u>74</u> rs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>		11. BIRTHPLACE (Country & State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William M. Clark</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Sheldon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>216-18-3993</u>		17. INFORMANT <u>Mrs. Elsie Kirby, 4606 Maine Av., Balto. 7, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> (b) <u>Arteriosclerotic Gangrene RT leg</u> (c) <u>Cerebral</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> <u>1960</u> to <u>4/9</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> <u>1961</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff</u>		22b. DATE SIGNED <u>4/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		22d. ADDRESS <u>4605 Edmondson Ave. 29</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		23d. LOCATION (City, town or county) <u>Baltimore County</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

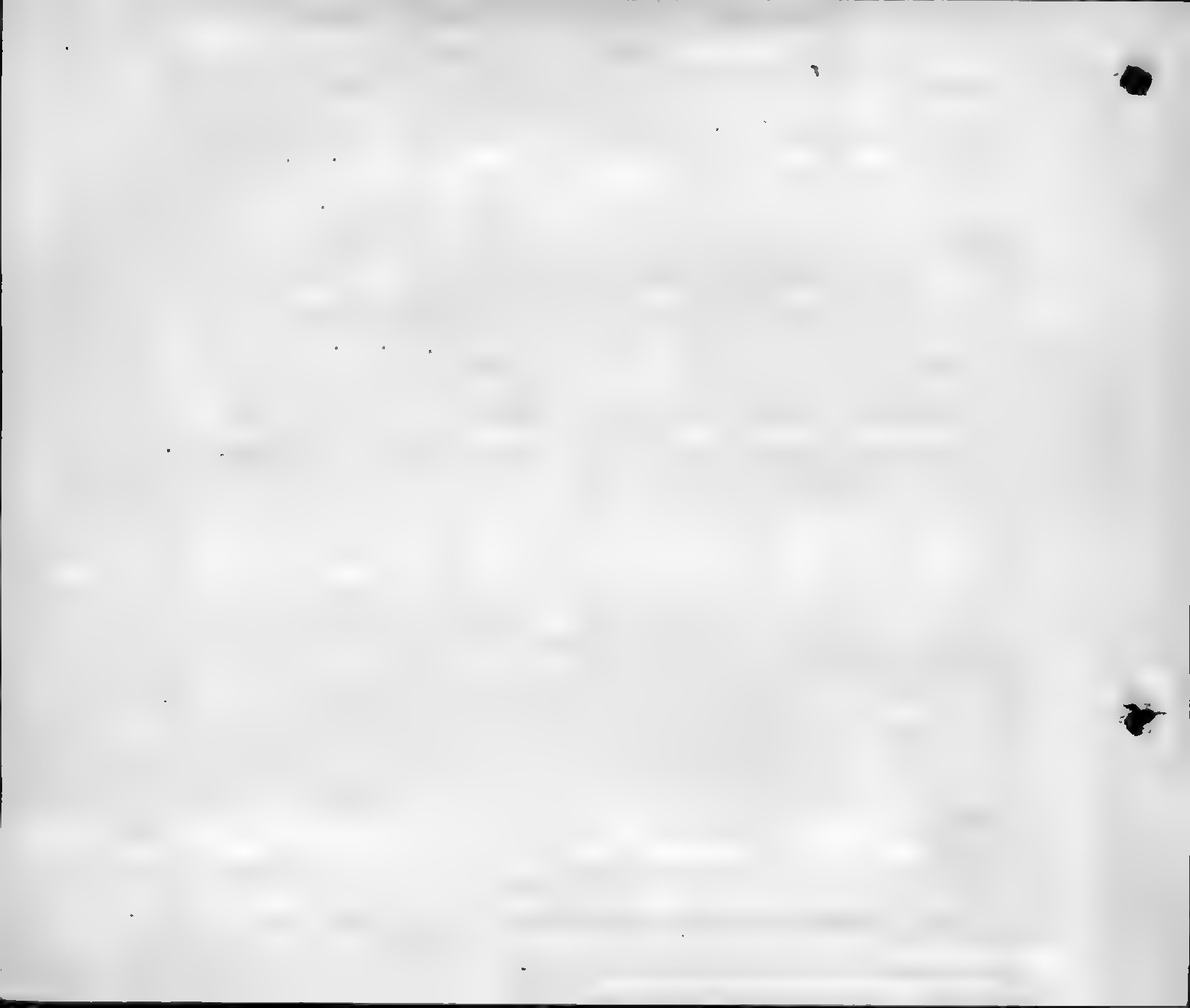
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04078

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8100 Old Phila. Road</u>		d. STREET ADDRESS <u>8100 Old Phila. Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Walter</u> Last <u>Walter</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HRS Hours <u>1</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Can Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jacob Walter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Taertlein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-4667</u>	
17. INFORMANT <u>Mr John Walter</u>		Address <u>8100 Old Phila. Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Arteriosclerotic Cardio Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>2 yrs</u> DUE TO (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>61</u> , to <u>4/7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/7</u> , 19 <u>61</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Balds 6 Md</u>		DATE SIGNED <u>4/7/61</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-11-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Stemore Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loach Funeral Home</u>		ADDRESS <u>7451 Belair Road</u>	
24a. REC'D BY REGISTRAR <u>APR 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4085

04079

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>44</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>214 E. Federal Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRED B. WATSON</u> First Middle Last		4. DATE OF DEATH <u>April 29 1961</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>January 16, 1896</u> Yrs. Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Orderly</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jones County, North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Madison Watson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW-1</u>		14. MOTHER'S MAIDEN NAME <u>Janie Cooper</u> 16. SOCIAL SECURITY NO. <u>Clinical Records, 3900 Loch Raven Blvd. Baltimore 18, Md. FORT HOWARD DIVISION</u>	
18. CAUSE OF DEATH (Enter only one cause pertinent to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } b) <u>GASTRIC HEMORRHAGE</u> c) <u>POLYCYSTIC KIDNEY DISEASE</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u> <u>40 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 16, 1961</u> to <u>April 29, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 29, 1961</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Norman P. Jones</u> 22c. PHYSICIAN'S NAME (Type) <u>NORMAN P. JONES, M.D.</u>		22b. DATE SIGNED <u>4/29/61</u> 22d. ADDRESS <u>VAH 3900 Loch Raven Blvd. Baltimore 18, Md. Fort Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-3-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph J. Collick</u>		25a. REC'D BY REGISTRAR <u>MAY 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

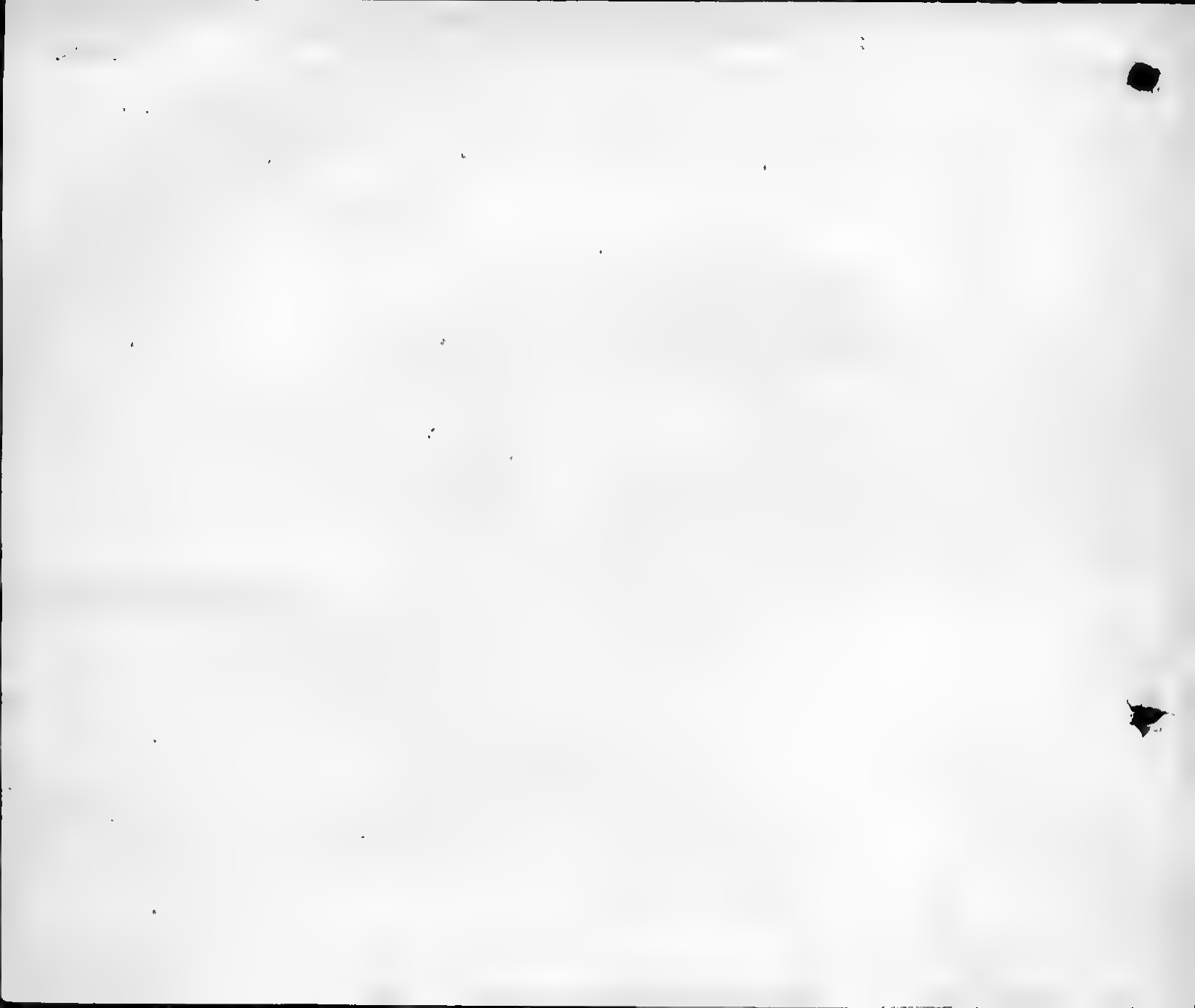
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4086

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04080

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28, Md. c. LENGTH OF STAY IN 1b 3yrs 10 mos + d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28, Md. (Catonsville) d. STREET ADDRESS 37 Bloomsbury Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle S. Last Ways		4. DATE OF DEATH Month April Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/80
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR: Months 11 Days 35	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. IF UNDER 24 HRS: Hours 11 Min 35	
13. FATHER'S NAME Deceased Henry Umbach		14. MOTHER'S MAIDEN NAME Deceased Catherine Spealman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4-2-1 DUE TO Arteriosclerosis, generalized, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized, severe (c) Arteriosclerosis, generalized, severe		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 p.m. 35		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 20, 1961 to April 20, 1961 that (I) (we) last saw the deceased alive on April 20, 1961 , and that death occurred at 11:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED April 21, 1961	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar		22d. ADDRESS Spring Grove State Hospital Catonsville 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/1961	
23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION (City, town, or county) (State) Howard Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home - Catonsville, Md.		25a. REC'D BY REGISTRAR APR 25 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kneal	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

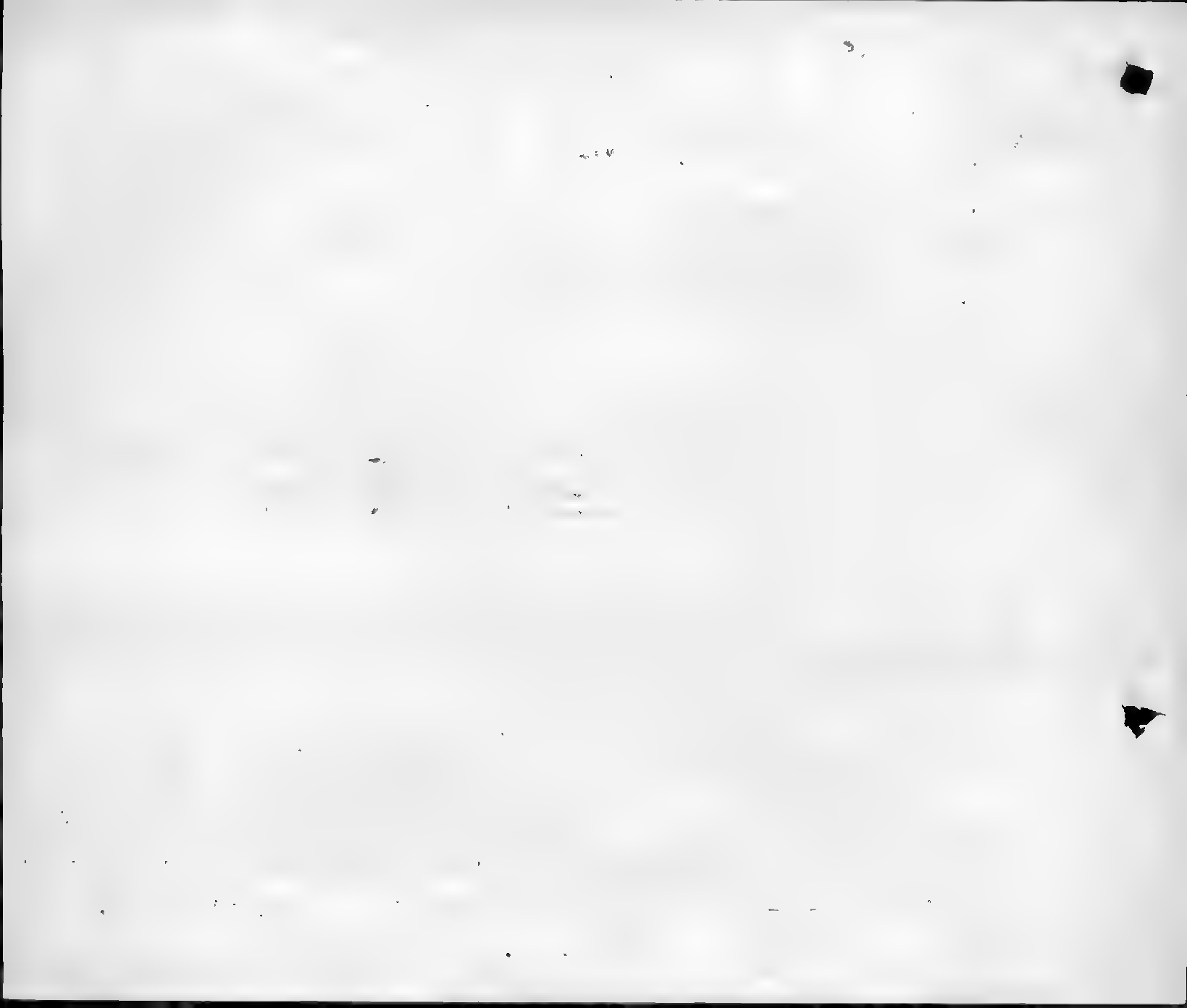
VR A15 (4)
15M 9/59

4087
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04081

1 PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 4 MO 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X TOWSON d. STREET ADDRESS 1121 Willow Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MOSELEY HOPKINS WEBB		4. DATE OF DEATH Month Day Year 4 19 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/90
9. AGE (In years last birthday, yrs) 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) LOUISIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MOSELEY H. WEBB		14. MOTHER'S MAIDEN NAME CILENIE VAUGHAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-01-7077	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 12X DUE TO FAR ADVANCED PULMONARY TUBERCULOSIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-30-1961 to 4-19-1961, that (I) (we) last saw the deceased alive on 4-19-1961, and that death occurred at 7:30 AM, from the causes and on the date stated above			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 4/19/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-22-61	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City, town, or county) (State) Cockeysville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md.		25a. REC'D BY REGISTRAR DATE APR 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hous			

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

VS. A18ME
5M 7/59

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FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
04082									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		f. FIRST ROGER		MIDDLE ---		LAST WEBB		4. DATE OF DEATH April 6 1961	
3. NAME OF DECEASED (Type or print)		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12/5/15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Harrisburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME Henry Webb		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 183-12-1813		17. INFORMANT Mildred Johnson		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED CERVICAL SPINE DUE TO Conditions, if any, which gave rise to immediate cause (b) PROBABLE FRACTURE OF SKULL (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARANOIA PSYCHOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from third story window VAH, Balto. Md. Ft. Howard Division		20c. TIME OF INJURY 1:05 p.m. 4/6/ 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, FT. HOWARD, MD. FORT HOWARD, BALTO. 19 MD.	
20f. (City or town) BALTO.		20g. (County) BALTO.		20h. (State) MD.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE MELVIN B. DAVIS, M.D.		DATE SIGNED 4/6/61							
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION OR REMOVAL (Specify) Removal		22b. DATE THEREOF 4-9-1961		22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Steelton, Pennsylvania	
23. FUNERAL DIRECTOR Arlington S. Phillips Funeral Home,		ADDRESS 1808 N. Monroe St., Balto 17, Md.		24. REC'D BY REGISTRAR APR 12 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Haines			



TO HOSPITAL OR ATTENDING PHYSICIAN: If law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

4083

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04083

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1717 Kurtz Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>1717 Kurtz Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ida Watts Weisbrod</u> First Middle Last 4. DATE OF DEATH <u>April 1, 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 19, 1882</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lucien Watts</u> 14. MOTHER'S MAIDEN NAME <u>Jennie Burnley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Family Records</u> 17. INFORMANT <u>Family Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (c) <u>5 YRS.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 MIN.</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 1, 1961</u> to <u>APRIL 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>MARCH 19, 1961</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William A. Pillsbury</u> 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u> 22b. DATE SIGNED <u>4-3-61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>2060 York Rd Timonium Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Apr. 3, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE APR 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

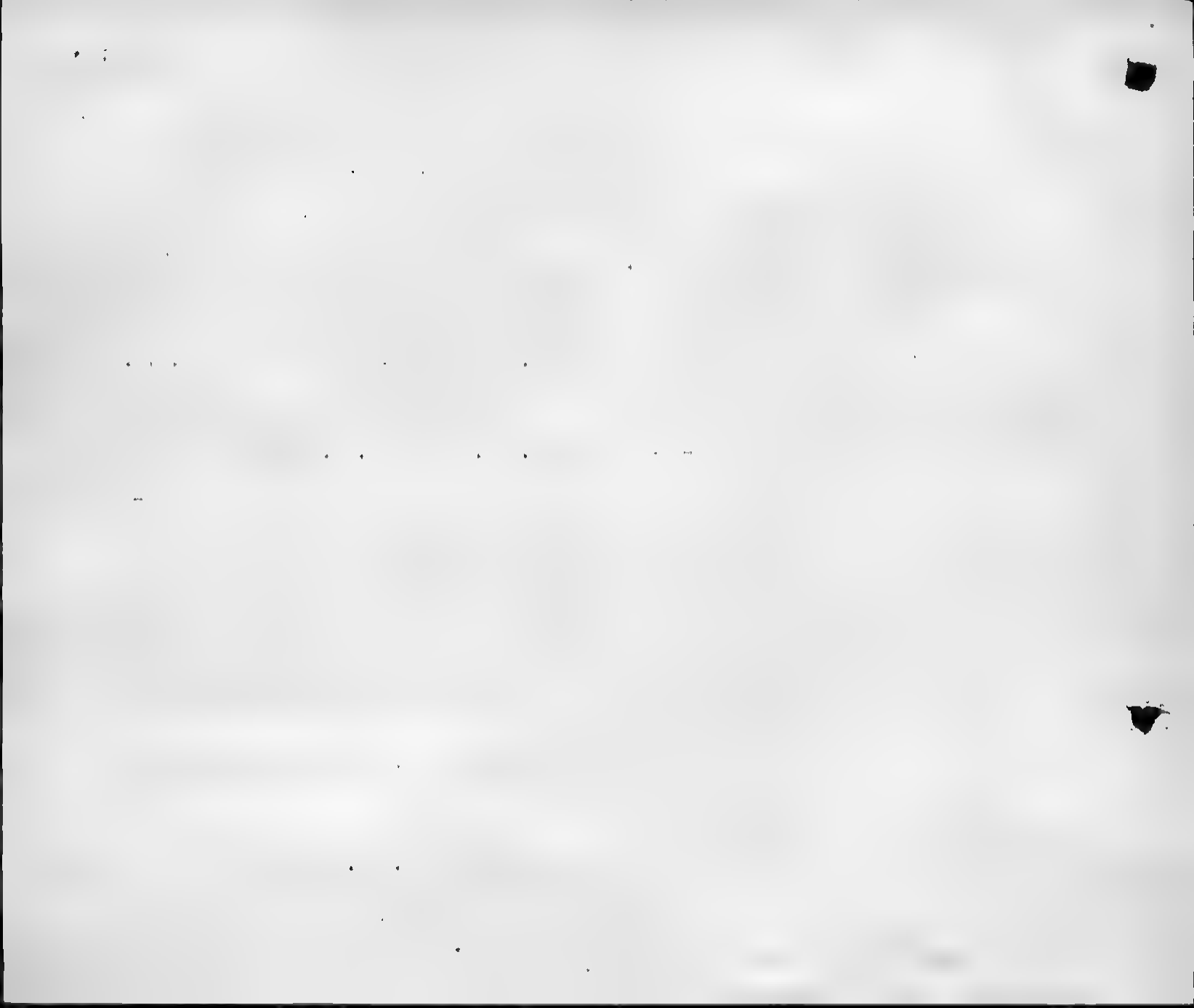
CERTIFICATE OF DEATH

04084

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> 18 Days c. LENGTH OF STAY N 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>22 New Jersey Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER</u> D. WENEPSKI First Middle Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>19 61</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>5/4/96</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bothlehem Steel Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael Wenerski</u> 14. MOTHER'S MAIDEN NAME <u>Theodora KOLANKIEWICZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>215-05-7360</u> 17. INFORMANT <u>Clin. Rec. VAH, Balto. Md. Fort Howard Division</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.4</u> DUE TO Conditions if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)		MYOCARDIAL INFARCTION ARTERIOSCLEROTIC HEART DISEASE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARAPLEGIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYNG <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11:25 PM</u> p.m.	
20d. INJURY OCCURRED <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) <u>VAH, Balto. Md. Fort Howard Division</u> (County) (State)	
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>March 20, 1961</u> to <u>April 7, 1961</u> that <u>14</u> (we) last saw the deceased alive on <u>April 7, 1961</u> , and that death occurred at <u>11:25 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Lawrence D Marcus</u> M.D. 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> 22d. ADDRESS <u>VAH, Balto. Md. Fort Howard Division</u> STAFF PHYS. <input checked="" type="checkbox"/>	
22b. DATE SIGNED <u>4/8/61</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/11/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u> 23d. LOCATION (City, town or county) <u>Glen Burnie, Maryland</u> 23e. ADDRESS <u>4200 Pennington Ave. Curtis Bay, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Fiakowski Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Curtis S. Kins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4091

CERTIFICATE OF DEATH

Reg. Dist. No. 04085

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 Yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor for Aged & Convalescents		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishkill	
f. STREET ADDRESS Main St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theophilus Wells		4. DATE OF DEATH Month April Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Methodist Conf.	
11. BIRTHPLACE (State or foreign country) Newfoundland (St. John's)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathaniel Wells		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Albert E. Wells		Address 828 Braeside Ave. (29)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 12, 1961 to April 18, 1961 , that I last saw the deceased alive on April 18, 1961 , and that death occurred at 8:30 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE George F. Knipp		DATE SIGNED April 19, 1961	
PHYSICIAN'S NAME (Type) George F. Knipp M.D.		ADDRESS (Street, city or town, state) 1116 Edmonson Ave. Balto., 29 Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4-19-1961	22c. NAME OF CEMETERY OR CREMATORY Pine Grove	22d. LOCATION (City, town, or county) (State) Massena, New York
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		24a. REC'D BY REGISTRAR DATE APR 21 '61	
ADDRESS 3207 W North Ave		24b. REGISTRAR'S SIGNATURE C. L. S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

4092

4086

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u> c. LENGTH OF STAY (If in hospital, give street address) <u>Waterfoot Farm</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Waterfoot Farm</u>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u> d. STREET ADDRESS <u>Waterfoot Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marion G. Wessel</u>		4. DATE OF DEATH <u>April 25, 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (County & State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William E. George</u>		14. MOTHER'S MAIDEN NAME <u>Lillie G. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Louis C. Wessel-Waterfoot Farm, Butler, Md.</u>		Address <u>Butler, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Cerebral Arterio Sclerosis</u> DUE TO (c) <u>Old Cerebral Thrombosis (6 weeks duration)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>Old Cerebral Thrombosis (6 weeks duration)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>3:40 p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hamstead, Md.</u>		20f. (City or town) <u>Hamstead, Md.</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March, 1961</u> to <u>4/25/61</u> , that (I) (we) last saw the deceased alive on <u>4/24/1961</u> and that death occurred at <u>3:40 p.m.</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>M. C. Porterfield</u>		22b. DATE SIGNED <u>APR 26 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>		22d. ADDRESS <u>Hamstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-28-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tuckner Sons</u>		25a. REC'D BY REGISTRAR <u>Baltimore 17, Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm J. Tuckner Sons</u>		25c. DATE <u>APR 26 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
M 9/60

4093

4093

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04087

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROUTE 13, BALTO. LI</u>	
c. LENGTH OF STAY IN 1b <u>13 yrs.</u>		d. STREET ADDRESS <u>145 POPLAR RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IDA MAE WEST</u>		4. DATE OF DEATH <u>4-18-1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1887</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WEST VIRGINIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY <u></u>	
13. FATHER'S NAME <u>STEPHEN HARTER QUEEN</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA ROBERTS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>JAMES WEST (HUSBAND)</u> Address <u>ABOVE</u>		18. CAUSE OF DEATH (Enter only one cause per line (a) (b) and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u>		10 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>April 17, 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Balto 6 Md.</u>		20f. (City or town) (County) (State) <u>BALTO 6 MD.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1961</u> to <u>April 18, 1961</u> that (I) (we) last saw the deceased alive on <u>April 17, 1961</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>John S. Connelly M.D.</u>	
22b. DATE SIGNED <u>4/19/61</u>		22c. PHYSICIAN'S NAME (Type) <u>John S. Connelly M.D.</u>	
22d. ADDRESS <u>Balto 6 Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>4-19-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SPENCER CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>SPENCER, WEST VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly M.D.</u>		25a. REC'D BY REGISTRAR <u>APR 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. DATE <u>APR 20 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the **death certificate be executed** within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

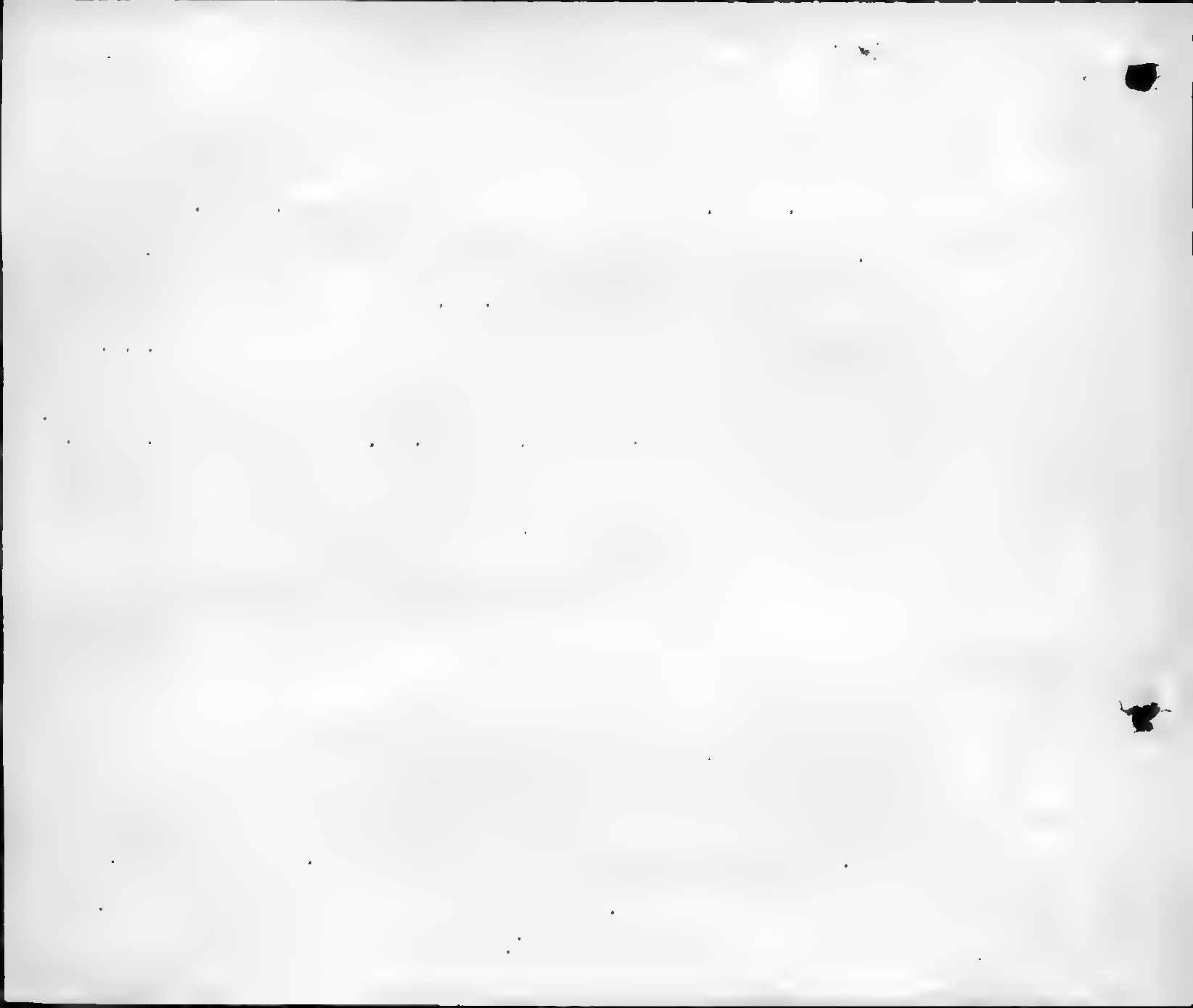
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4094

Items 8 & 9 Film 284 4/11/61 iwk

04088

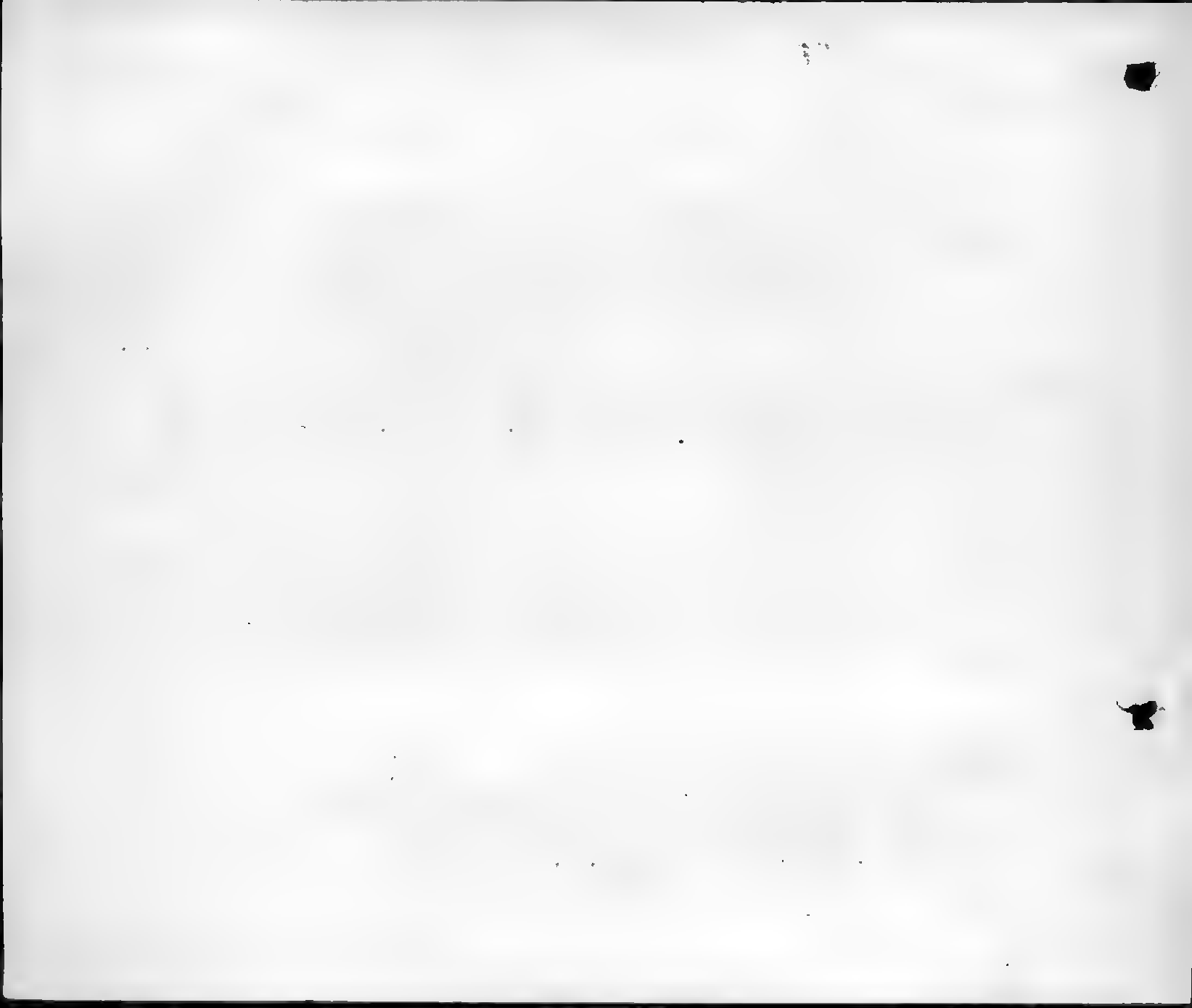
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3304 Rolling Rd. Balto. 7		d. STREET ADDRESS 3304 Rolling Rd. Balto. 7	
3. NAME OF DECEASED (Type or print) First Mr. Ruben Middle Edward Last Whitcomb		4. DATE OF DEATH Month April Day 3 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1884 Nov. 16, 1907
9. AGE (In years last birthday) 77 7/8 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 19 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Digger Operator		10b. KIND OF BUSINESS OR INDUSTRY Well Digging	
11. BIRTHPLACE (State or foreign country) Glyndon, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Whitcomb		14. MOTHER'S MAIDEN NAME Ruth Fuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-03-8443	
17. INFORMANT Mrs. Annie A. Horne		Address 3304 Rolling Rd. Balto. 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic pneumonia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration C.V. Renal lesion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from July 15, 1956 to 4/3, 1961 , that (I) was last saw the deceased alive on 4/2, 1961 , and that death occurred 8:30 AM , from the causes and on the date stated above.		INTERVAL BETWEEN ONSET AND DEATH 10 Years	
22a. SIGNATURE Edwin Pierpont		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Edwin Pierpont		22d. ADDRESS 8204 Liberty Rd. Baltimore 7, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Randallstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR APR 7 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Fenn			



Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completed by the attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
4095
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04089

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 1209 Linden Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alfred Middle Charles Last White				4. DATE OF DEATH Month April Day 16 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 30, 1926	
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min —		11. IF UNDER 24 HRS. Months — Days — Hours — Min —		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown Stanley White				14. MOTHER'S MAIDEN NAME Unknown Marie Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes Army PFC 1952-55				16. SOCIAL SECURITY NO. 212-220-546		17. INFORMANT Mrs. Dorothy S. Snair-1825 Palmer Avenue Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MODERATE ARTERIAL HYPERTENSION - ALCOHOLISM						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 30, 1961 to April 16, 1961 that (I) (we) last saw the deceased alive on April 15, 1961 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Aristides Simopoulos				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4-17-61	
22c. PHYSICIAN'S NAME (Type) Aristides Simopoulos, M. D.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-20-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE —				25a. REC'D BY REGISTRAR —		25b. REGISTRAR'S SIGNATURE —	
25c. DATE APR 19 1961				25d. REGISTRAR'S SIGNATURE —			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

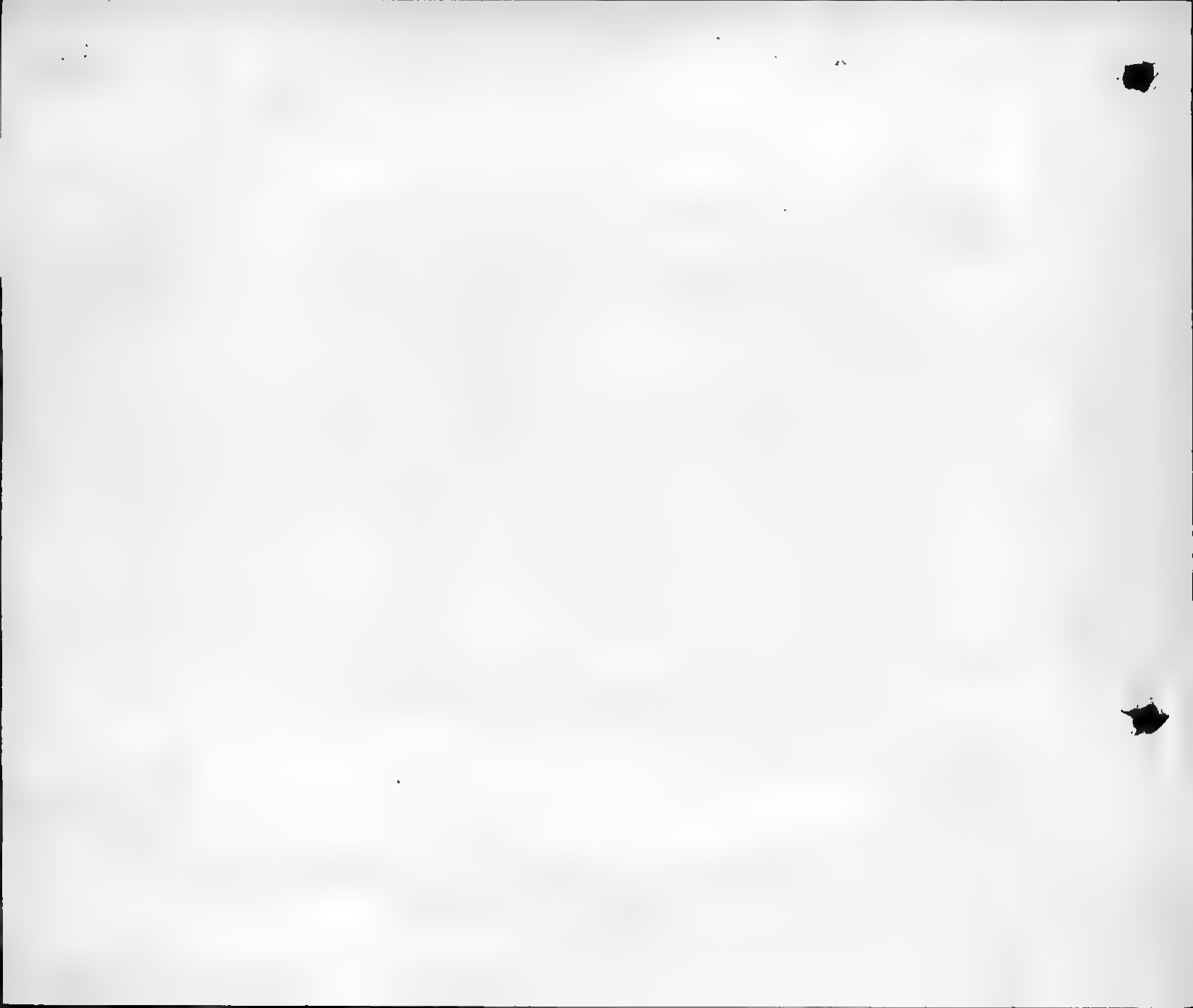
1

4086

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04090

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 4yrlmth25days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 336 East 25th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Juanita Middle Whittle Last Whittle		4. DATE OF DEATH Month April Day 10 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1872
9. AGE (in years last birthday) 89 yrs		10. IF UNDER 1 YEAR Months — Days — Hours — Min —	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12. KIND OF BUSINESS OR INDUSTRY —	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Thomas Whittle		16. MOTHER'S MAIDEN NAME Bardelia O'Brien	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO. unknown	
19. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Arteriosclerotic cardiovascular disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from Feb. 15 9:00 to April 10 1961 , that (I) (we) last saw the deceased alive on April 10 1961 , and that death occurred at 2 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar, M. D.		22b. DATE SIGNED 4-10-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-13-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemo.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Garley - Granady & FH - Catonsville, Md.		25a. REC'D BY REGISTRAR APR 14 '61	
25b. REGISTRAR'S SIGNATURE Charles L. Hanna		25c. DATE APR 14 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATIS (4)
15M 9/59

4097

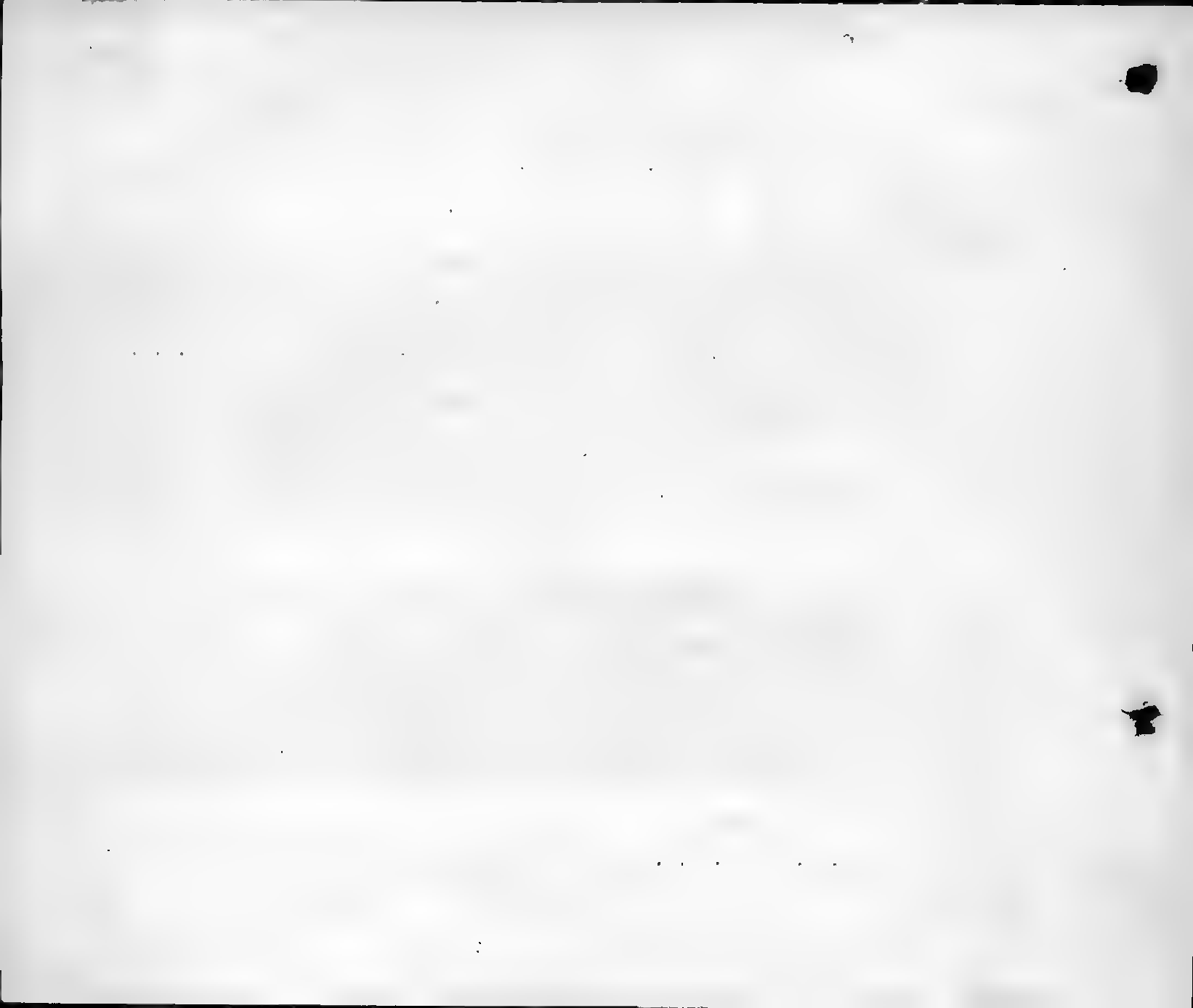
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04091

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>5Yrs. 6Mos. 29Das.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>THE SHEPPARD AND ENOCH PRATT HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
f. STREET ADDRESS <u>720 S. Lee Street</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Frederick Mark Wickham</u>		4. DATE OF DEATH Month Day Year <u>April 27 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 7, 1879</u>
9. AGE (In years lost birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>Quebec, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Martin Wickham</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anne Swift</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>"</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 yrs +</u> <u>"</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Brain Synd. due to Central arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28, 1955</u> to <u>April 27, 1961</u> that (I) (we) last saw the deceased alive on <u>April 26, 1961</u> , and that death occurred at <u>1:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. W. Elgin</u>		22b. DATE SIGNED <u>April 27, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. W. Elgin, M.D.</u>		22d. ADDRESS <u>Towson 4, Maryland</u> <u>The Sheppard and Enoch Pratt Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-29-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. & Son Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4098

Items 1 & 2 Film G285 4/18/61 iwk

04092

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland, Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7405 Bay Front Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Andrew L. Williams		4. DATE OF DEATH Month Day Year April 7, 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/3/81
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroader		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania R.R.	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME David Williams		14. MOTHER'S MAIDEN NAME Sarah Wood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 716-10-6115	
17. INFORMANT Mrs. Louise L. Williams, 7405 Bay Front Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 177X DUE TO CARCINOMA OF PROSTATE WITH METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 8-12 Mths.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/10/1960 to 4/7/1961 , that (I) (we) last saw the deceased alive on 4/7/1961 , and that death occurred at 4:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Barnett Berman		22b. DATE SIGNED 4/11/61	
22c. PHYSICIAN'S NAME (Type) BARNETT BERMAN, M.D.		22d. ADDRESS 714 PARK AVE., BALTO. 1	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/11/61	23c. NAME OF CEMETERY OR CREMATORY Glen Haven	23d. LOCATION (City, town or county) (State) Anne Arundel Co. MD
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.		25a. REC'D BY REGISTRAR APR 13 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4093

04093

M

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1521 Lemon St. Balto 23, Md.</u> d. STREET ADDRESS <u>1521 Lemon St. Balto 23, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES E. WILLIAMS</u> First Middle Last 4. DATE OF DEATH <u>April 8 1961</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>December 7, 1897</u> 9. AGE (in years last birthday) <u>63</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 11. BIRTHPLACE (County & State or foreign country) <u>Laurel, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Williams</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>WW-1 218-10-5191</u> 17. INFORMANT <u>Eliza Williams</u> Address <u>Clinical Records, 3900 Loch Raven Blvd. Baltimore 18, Md.</u>		14. MOTHER'S M maiden name <u>Eliza Williams</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE PULMONARY INFARCTIONS</u> DUE TO <u>EMBOLI FROM LEFT ATRIAL THROMBUS</u> with <u>ARTERIOSCLEROTIC HEART DISEASE</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCR. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>April 5 1961</u> Hour a.m. <u>3:00</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from <u>April 5 1961</u> to <u>April 8 1961</u> that (we) last saw the deceased alive on <u>April 8 1961</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Lawrence D. Marcus</u> 22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE D. MARCUS, M.D.</u> 22b. DATE SIGNED 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-12-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u> 25a. REC'D BY REGISTRAR <u>APR 12 '61</u> 25b. REGISTRAR'S SIGNATURE <u>C. S. K...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04094

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 605 S. Pulaski Street	
3. NAME OF DECEASED (Type or print) ELMER R. WILLIAMS		4. DATE OF DEATH April 6 1961	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH January 8, 1894	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Williams		14. MOTHER'S MAIDEN NAME Mollie Childs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 705-09-1589	
17. INFORMANT Clin. Records, VAH, Balto. Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH DUE TO 151X Conditions, if any, which gave rise to immediate cause (b) CARCINOMATOSIS (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 21, 1961 to April 6, 1961 , that (it) (we) last saw the deceased alive on April 6, 1961 , and that death occurred at 4:55AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan M.D.		22b. DATE SIGNED 4/6/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M. D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 4-10-61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	
23d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas F. Crahan		25a. REC'D BY REGISTRAR APR 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS SCHWAB FUNERAL HOME, 2101 Frederick Ave. Balto. Md.	

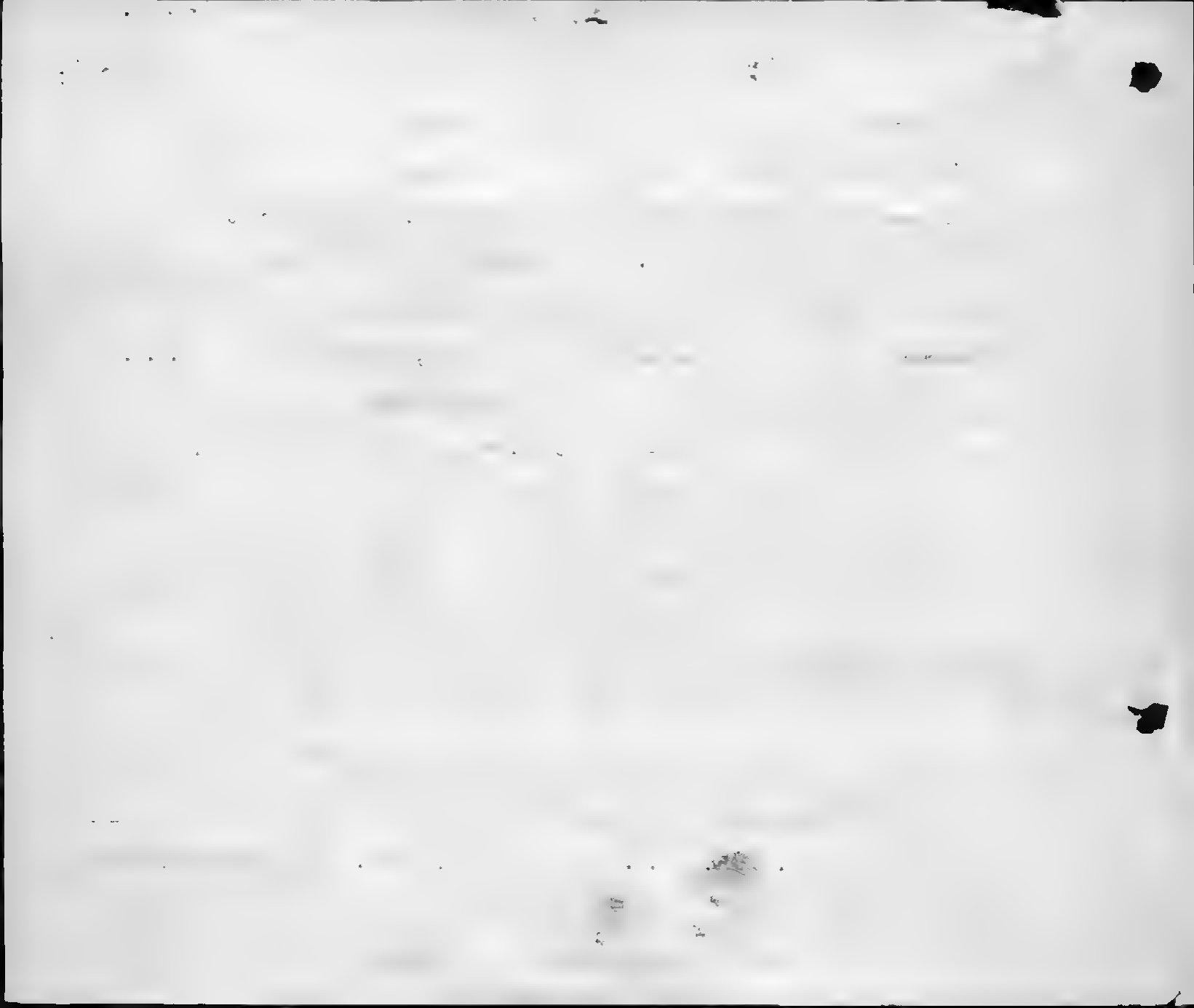
VR A15 (4)
15M 9/60



04095

Arthur L. Kraus

VR A15 (4)
15M 9/60

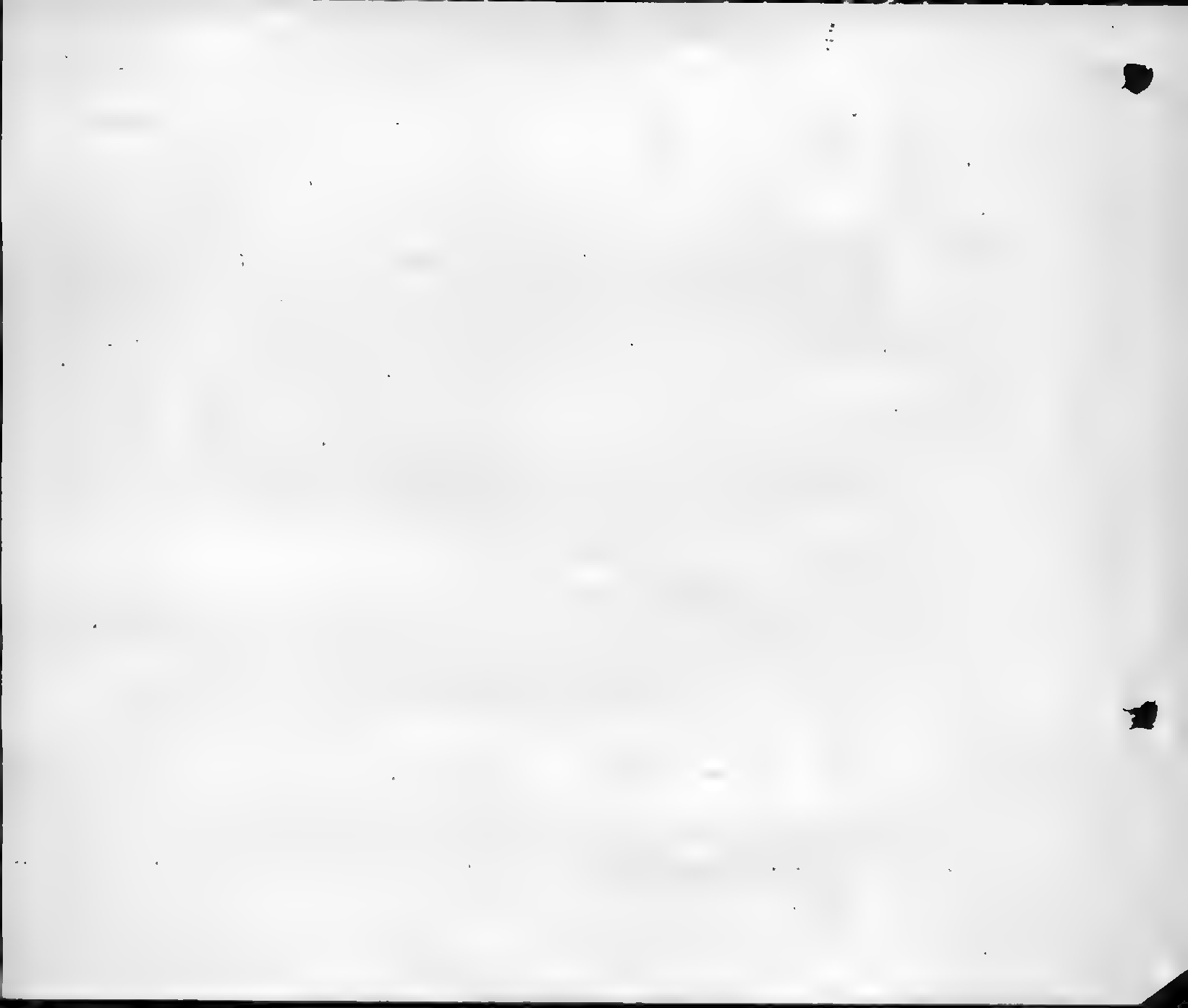


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

4-7-61

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 3 months						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood 12 X d. STREET ADDRESS Box 529 1 Tupelo Place							
3. NAME OF DECEASED (Type or print) DORIS First ESTELLE Middle WILSON Last 4. DATE OF DEATH Month 4 Day 4 Year 1961						5. SEX F 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2.14.1926 9. AGE (In years last birthday) 35 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Housework 11. BIRTHPLACE (State or foreign country) Edm City, N.C. 12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOSEPH T. COBB 14. MOTHER'S MAIDEN NAME ADDIE MAE LANDING						15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Hospital Records, Mt. Wilson State Hospital Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO (b) 13 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1.2.6. 1961 , to 4.4 1961 , that (I) (we) last saw the deceased alive on 4.4 1961 , and that death occurred at 4:30 M, from the causes and on the date stated above.													
22a. SIGNATURE W. Newcomer M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4.4.1961							
22c. PHYSICIAN'S NAME (Type) W. Newcomer, M.D., Superintendent						22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 7, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Cemetery				23d. LOCATION (City, town, or county) (State) Fountain Green, Harf. Co., Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster						ADDRESS W. Broadway & W. Williams Street BEL Air, Maryland							
25a. REC'D BY REGISTRAR DATE APR 6 '61						25b. REGISTRAR'S SIGNATURE Arthur L. Thomas							



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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

4103
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04097

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Starleigh c. LENGTH OF STAY in lb Starleigh d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6803 York Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1339 W. North Ave -7 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK MORAN WILSON		4. DATE OF DEATH Month April Day 28, Year 19 61	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1916
9. AGE (in years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 4 Days 15	11. IF UNDER 24 HRS. Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Littleton, N. C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Wilson		14. MOTHER'S MAIDEN NAME Hattie Vinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216-01-7896	
17. INFORMANT Louise Wilson - 1339 W. North Avenue		Address 1339 W. North Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr., M. D.		DATE SIGNED April 29, 1961	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or country)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1961	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave., Balto., Md	
24a. REC'D BY REGISTRAR MAY 2 '61		24b. REGISTRAR'S SIGNATURE Charles R. Law	



Item 18 Film 286 5-1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus
c. LENGTH OF STAY IN 1b _____
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1211 Greystone Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE X Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus
d. STREET ADDRESS 1211 Greystone Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) MARY LELIA WILSON
4. DATE OF DEATH April 24, 1961
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH July 11, 1908 9. AGE (In years last birthday) 52 yrs.
IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady
10b. KIND OF BUSINESS OR INDUSTRY Montgomery-Wards Kentucky
11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James W. Keatts
14. MOTHER'S MAIDEN NAME Inez Shelton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-01-1070 17. INFORMANT Wm. J. Wilson Address 1211 Greystone Rd. #27

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
422.1 DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

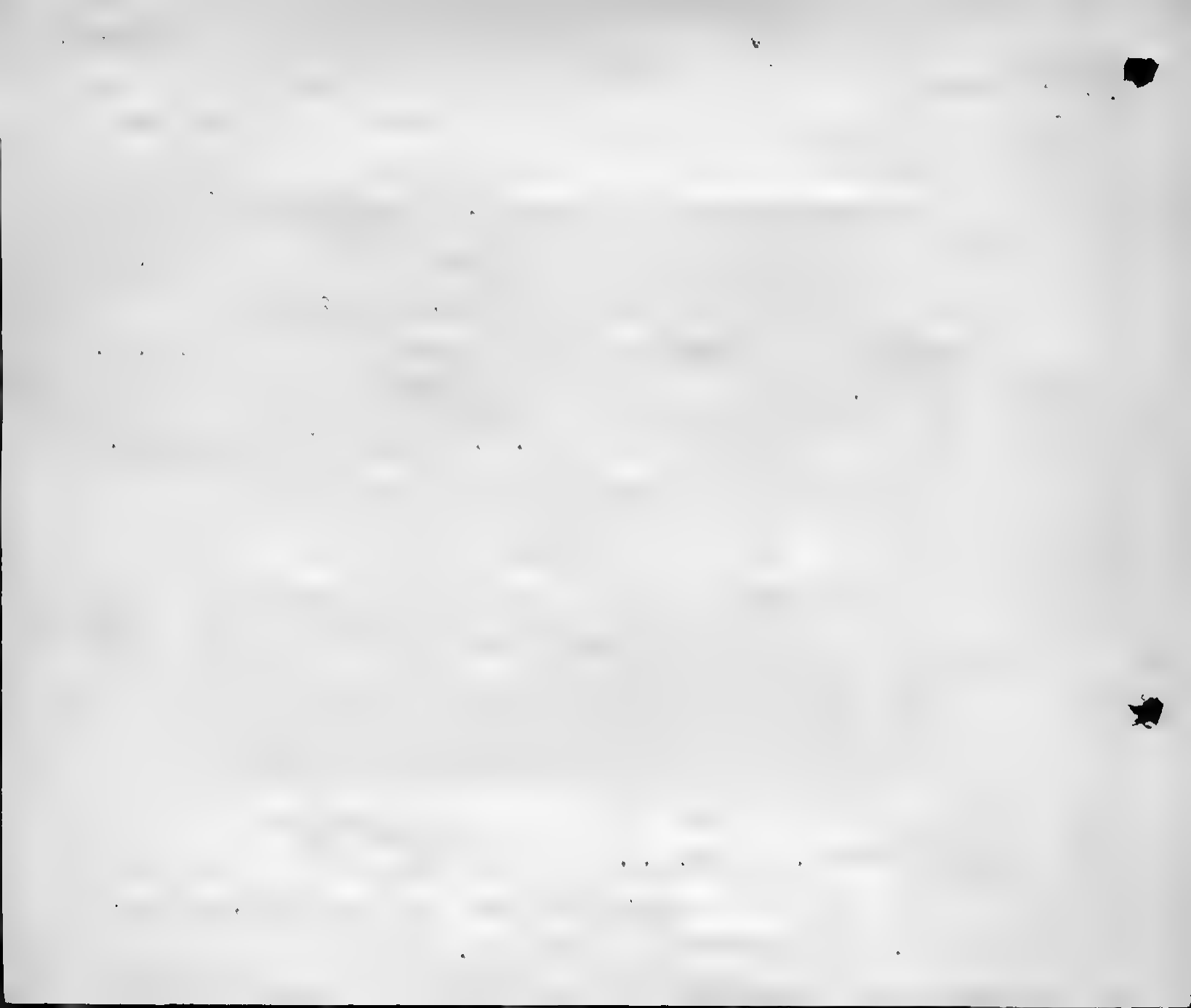
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐
ACTUAL SIGNATURE Peter W. Rieckert M.D. Medical Investigator DATE SIGNED 4/24/61
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D. Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/27/61 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery 22d. LOCATION (City, town, or country) (State) Baltimore, Maryland

23. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 24a. REC'D BY REGISTRAR APR 26 '61 24b. REGISTRAR'S SIGNATURE Arthur P. H.



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4105

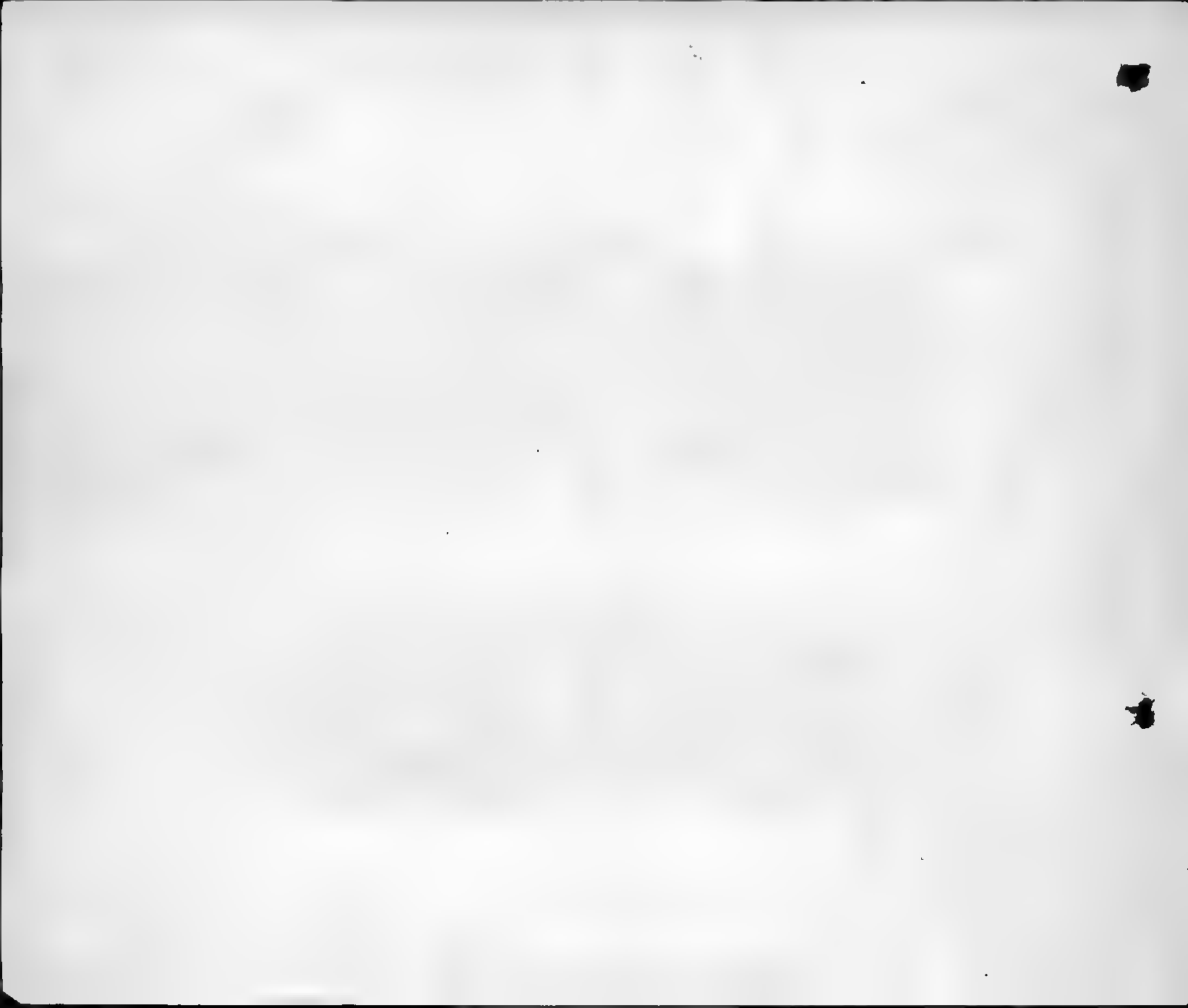
CERTIFICATE OF DEATH

Reg. Dist. No.

04099

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X White Marsh</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1896 Carrington Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH WUNDER</u>				4. DATE OF DEATH <u>April 24 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-21-90</u>	
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Balto. City</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>216-01-3131</u>		17. INFORMANT <u>Wife (same as above)</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X LIREMIA</u> DUE TO (b) <u>CHRONIC GLOMERULAR NEPHRITIS 24 yrs.</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASC. DIS. 10 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Nat white</u> <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>61</u> , to <u>4/24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>61</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson, M.D.</u>				ADDRESS (Street, city or town, state) <u>FORK, MD.</u>			
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly</u> ADDRESS <u>418 Eastern Blvd.</u>				24a. REC'D BY REGISTRAR <u>APR 27 61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Union S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital. Attending physician may be retained by the hospital. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4107
CERTIFICATE OF DEATH

04101

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stansbury Mill Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hattie Middle May Last Zinkhan				4. DATE OF DEATH Month 4- Day 8- Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-18-1885	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nurse		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Howard Troyer				14. MOTHER'S MAIDEN NAME Annie Melvin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-20-5578		17. INFORMANT Mrs. Shelben Thompson Phoenix, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Intestines 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from December 20 1960 to March 31 1961 , that (I) (we) last saw the deceased alive on March 31 1961 , and that death occurred at 6 AM , from the causes and on the date stated above.							
22a. SIGNATURE Theodore G. de Cueva				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 10, 1961	
22c. PHYSICIAN'S NAME (Type) Theodore G. de Cueva				22d. ADDRESS Cockeysville - Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-61		23c. NAME OF CEMETERY OR CREMATORY Jacksonville Reform		23d. LOCATION (City, town, or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Maryland				25a. REC'D BY REGISTRAR APR 17 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

10140

STATE OF NEW YORK

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